

# Perceptions of Family Centred Care for Children in Ghana Hospitalised through Road Traffic Accident

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## Declaration

I, Lillian Akorfa Ohene, hereby declare that this thesis and the work presented in it are my own and has been generated by me as a result of my own original research.

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## Abstract

Road traffic accident (RTA) is one of the leading causes of injuries and hospitalisation of children in Ghana. The sudden hospitalisation of the injured child is associated with anxieties and stressful episodes for the affected families. Family Centred Care (FCC) is a concept in paediatric nursing, which forms the basis of care for sick children and their families. FCC as a product of social constructs differs in cultures and context, despite the universal principles underpinning the concept. There is a perceived lack of knowledge of the concept in childcare practice in Ghana. This study explored the perspectives of FCC among health professionals and parents of children hospitalised through RTA in Ghana. The study adopted a qualitative approach, underpinned by a constructivist grounded theory methodology. Data was generated through in-depth individual interviews using a semi-structured technique. Participants consisted of twenty-four professionals and nineteen parents. Data were analysed using a constant comparative approach and two core categories emerged. Parental presence emerged from parents' perspective, which generated four sub-categories. These include; managing emotions, negotiating the system, parental care roles, and challenges encountered. The professionals' interviews generated family involvement; its sub-categories are parental involvement, communication, setting boundaries and support for family involvement. The emerging model of parental presence and family involvement for the care of the injured child in the hospital is the first of its kind in Ghana. The dimensions of negotiating the care system, which includes parents negotiating their social status with the professionals, also, demonstrating their usefulness in the hospital and establishing acquaintances with persons with influential powers within the socio-cultural context of Ghana forms part of key findings and the contribution to knowledge. The outcome of discussing the findings within the existing literature was projected using the Force Field Analysis as a conceptual framework for family involvement in the medico-cultural context of Ghana. The study recommends that institutional policies should reflect family involvement practice evidenced by clear written protocols for the involvement of parents/family in the care of the in-patient child.

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## Glossary

**The child** in the Ghanaian context refers to any person under the age of 18, who is largely dependent on an adult for the necessities of life.

**A family** is a group of people related by blood, marriage, law (in the case of adoption), collective identity as well as lineage and ethnic group.

**Nuclear family** refers to a group that consists of only the mother, father and children.

**Extended family** refers to a family that includes the nuclear family and near relatives.

**Ghana**, officially known as the Republic of Ghana, is a multicultural, low middle-income country located along the Gulf of Guinea and the Atlantic Ocean, in the sub-region of the West Africa.

**Ghana health service** is an independent Executive Agency responsible for implementation of national health policies under the control of the Minister for Health, Ghana.

**Healthcare institutions** in this context refer to a facility that provides a short or long-term care, mainly such as the hospital.

**Health professionals** also referred to as professionals or clinicians in this document are primarily doctors, nurses, and midwives who provide preventive, curative and rehabilitation services in the hospital.

**Ministry of health** is the government agency responsible for all health issues in Ghana. It oversees the formulation of policies, monitoring and evaluation, resource mobilisation and regulation of health service delivering in Ghana.

**Parent** is any family member(s) who is the caregiver for the child.

**Road Traffic Accident**, also known as traffic collision or motor collision refers to a collision of a moving vehicle with another, pedestrian, animal or any substance for which there is a significant impact.

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# 1 Chapter 1: Introduction to the study

## 1.1 Introduction

Road traffic injury is one major cause of hospitalisation of children in Ghana (Abantanga and Mock, 1998; Adesunkanmi et al., 2000). The admission of children in a country like Ghana where there is limited medical resources, weak administrative systems, abject poverty and low level of education comes with many challenges (Hyder, Muzaffar and Bachani, 2008). Children hospitalised in Ghana experience long duration of hospital stay, physical and emotional instabilities, deprivation of parental care, and many more difficulties.

An attempt to identify the causes and find solutions to challenges faced by hospitalised children and their families in Ghana revealed that these problems are not unique to the Ghanaian context specifically. The literature records devastating effects of RTA on children in many countries as well. Among these are prolonged healing periods ranging from months to years and the subsequent burden on families (Batailler et al., 2014; Nguyen et al., 2013; Alisic et al., 2014; Langeland and Olff, 2008).

Context-appropriate care concepts are available in dealing with specific issues of hospitalised children and their families (Alisic et al., 2014). One of such concepts, widely explored and comprehensively endorsed in paediatric practice is Family Centred Care (FCC) (Shields, 2015). Thus, the FCC concept is one of the core principles in paediatric health practice that recognises the health needs of the

sick children and their families caring for them in the hospital. It emphasises that the sick child and the entire family receive attention and support during hospitalisation of the child. Shields and King (2001a) recommend the practice of FCC in children's units in hospitals to help meet the needs of families in a supportive way. This study explored perceptions of FCC in Ghana, given the recognition that it is accorded globally in child health practice (Shields and King, 2001b; Alsop-Shields and Mohay, 2001a).

This chapter details the background to the study. The geographical and social contexts are described. These include the geographical location of Ghana, social patterns, family systems and values in Ghana. The value of children within the cultural context of Ghana is further highlighted. An overview of the healthcare system with emphasis on care services to children is similarly outlined. Finally, the outlines of the subsequent chapters of the thesis are also featured.

## 1.2 The background to the study

In the year 2011, Ghana began to train certified paediatric nurses, a significant achievement and milestone in child healthcare in the country. The training programme initiated by SickKids Hospital Toronto, in collaboration with the University of Ghana, Ministry of Health Ghana, Nurses and Midwives Council of Ghana; and sponsored by Canadian International Development Agency, is a one-year post basic diploma course for registered nurses to become specialists in paediatric nursing practice. I was among the 40 students in the first cohort of the

paediatric nurse specialist training in March 2011. The training offered student trainees the opportunity to encounter children with many disease conditions and ill health challenges. The leading causes of hospitalisation among children were injuries from Road Traffic Accidents (RTA) and burns from domestic fires. I took a keen interest in the RTA cases due to my previous background in researching into the nursing management of adults involved in RTA at the postgraduate level of my education. In addition, the paediatric programme introduced the FCC concept as one of the major principles of paediatric care.

In Ghana, RTA is a major public health problem (Ackaah and Adonteng, 2011; Aidoo, Amoh-Gyimah and Ackaah, 2013; Mock et al., 2005; Mock, Amegashie and Darteh, 1999; Mock, Forjuoh and Rivara, 1999). Despite the increased toll of RTA on both human and material resources, there is a scarcity of empirical data to explain the menace in the Ghanaian context. The available evidence indicates that for about a decade, RTA remains one of the ten leading causes of death in Ghana (Rominski et al., 2011). It is estimated that approximately 1900 fatal RTAs occurs every year, and that figure is expected to rise by the year 2020 (Damsere-Derry et al., 2010; Murray et al. 2010). A three-year study conducted between the years of 2005 to 2007 recorded 5,639 deaths, and a detailed analysis revealed that pedestrians alone constitute 42% of these deaths. Children pedestrians formed as high as 32.9%, almost one-third of the total deaths (Ackaah and Adonteng, 2011).



Evidence shows that over the years, RTA is one of the leading causes reported at casualty units of tertiary and teaching hospitals in Ghana (Korle Bu Teaching Hospital, 2016). For example, in 2012, about 12,376 patients reported with one or a combination of the top ten conditions at the hospitals' casualty unit. Patients reporting with RTA alone constituted 4,767 and this forms the number one cause of admissions as a result of road traffic injuries at the emergency unit. This figure comprises both adult and children. Although the admissions of RTA are increasing over the years, there seems to be limited data on children alone.

The ramifications of RTA in Ghana are substantial. The financial and emotional implications following RTA on individuals, families and Ghana's economy are similarly significant. Families carry the burden of responsibility for the care of their family members involved in RTA and this includes financial responsibilities. In most cases, families travel far away from home to access specialist care in the cities for a member who gets involved in an RTA. In addition to the cost burden on families, the loss of working time, labour and other resources during care is very significant. Further challenges to families are the skills required to care for relatives involved in an RTA who sometimes end up with long-term disabilities (Alisic et al., 2014). Individual victims are also subjected to physical and emotional traumas, and long-term disabilities (Clarke et al., 2012).

It is estimated that about 1.6% of Ghana's gross domestic product is spent on RTA's alone, amounting to about 1.0 billion USD per annum (Ackaah and Adonteng, 2011). Furthermore, the health care system also faces challenges with

the care of RTA victims. Until recently, medical emergency care for trauma patients was lacking in Ghana (Osei-Ampofo et al., 2013). Just about the same year of starting the paediatric nursing training programme, training of various cadres of health workers in trauma care was also initiated (Bell et al., 2014). There are only a few medical facilities for managing physical injuries, and these are scattered in only few cities in Ghana.

This research recognises the many efforts by governments and non-government organisations directed at cost effective interventions to curb the menace of RTA in Ghana. The targeted areas of these interventions include the reduction of road accidents due to human errors and bad roads. For example, there are ongoing national road safety campaigns that run periodically in a year. Drivers are sensitised on common causes of RTA, such as drink driving and speeding. Furthermore, drivers and other motorists are screened for conditions such as eyesight and hearing before a licence is granted. In addition, attempts are being made to construct safer new roads while the dangerous old roads are undergoing reconstruction to improve visibility at night (Mock, Amegashie and Darteh, 1999). Also, there are periodic first aid training sessions to equip commercial drivers with basic life-saving skills to enable them to respond to injured persons in cases of RTAs.

The training of health workers to manage RTA victims and other traumatic emergencies is one area that has also seen major improvement. In 2004, the national ambulance service was established, and the training of pre-hospital care

team began. Although the pre-hospital care is not the physician-led team, handling of victims on board the ambulance arrive at the hospital in better conditions than victims who arrived in private and public transports (Nee-Kofi Mould-Millman, Rominski and Oteng, 2014). Further health training for physicians and nurses in medical emergencies have commenced in 2009 and 2010 respectively. Currently, the emergency care training in Ghana is located at the Kwame Nkrumah University of Science and Technology at both undergraduate and graduate levels. The few physicians and nurses who have graduated from these training programs are practising in tertiary healthcare facilities located in cities in Ghana (Bell et al., 2014).

The recent establishment of specialised paediatric nursing and emergency trauma training in Ghana suggest that there are renewed efforts by the Ghana healthcare institutions towards the attainment of global standards in child health care. As such, there should be ongoing research in these fields of nursing care to identify gaps in care and practice. Credible research is one important way to bridge the gap between theory, education and practice that can directly contribute to improving care and patients outcomes (Elliott and Jordan, 2010; Cartagena et al., 2012). The Ghanaian nurse is well positioned to contribute to this act of researching into the care principles in paediatric health care. This research, therefore, focused on the care of children involved in RTA at two tertiary level hospitals. The perceptions of FCC concept among parents and health professionals were explored in this study.

### 1.3 Rationale for the study

During my years of practice as a nurse clinician, I have developed a particular interest in helping families who are dealing with the trauma of hospitalisation, especially the very vulnerable families who often seemed lost, confused and frustrated with the healthcare system in Ghana. The services that I rendered to relatives in these situations were often within the realms of emotional and financial assistance. After offering several of such personal assistance, I began asking rhetorical questions. “Why are there so many frustrated families within the hospital settings”? “Are there any ways to curtail this trend”? While contemplating on solutions to these problems, I had the opportunity to do a one-year continuous professional development course in specialist paediatric nursing. The paediatric specialist-nursing program introduced me to the concept of patient-and-family centred care. This concept gave me an in-depth insight into respect for patient and families, maintaining patient dignity, as well as supporting patients and families to make the hospital experience less painful.

As part of the specialist course, I also had the opportunity to undertake clinical placements in various children’s units. This clinical experience further aroused my curiosity about practices that could support patients’ families in a better way. Friendly discussions with colleague nurses and personal investigations suggested the lack of empirical evidence on the concept of patient and family centred care nursing practice in Ghana. Consequently, I developed the

motivation to pursue research into FCC at a higher level. This was also in line with my career aspirations.

An additional driver, which ensured that the passion for conducting this research materialised stemmed from the mandatory requirement for all teaching professionals in higher education in Ghana to acquire a postgraduate certification (PhD) to secure their employment. This move was based on the argument that most PhD programmes involve intensive research, and also help students to establish their niche in the research arena, which is an important aspect of the transition from a nurse to a nurse scientist (Armstrong, McCurry and Dluhy, 2017). Others also argued that learning to communicate effectively in a scholarly format is an essential requirement for the nurse scientist. Thankfully, these essential scholarly skills are incorporated into most PhD programmes (Postal and Griffioen, 2013; Zebelman, 1988). Thus, the main motivational factors for this research have been a combination of both extrinsic and intrinsic ambitions, which include:

- To discover and contribute new knowledge in the field of healthcare provision, which would help shape policies in the Ghanaian context, and potentially be of regional and global relevance.
- To gain knowledge and scholarly skills for the smooth transition and survival in the field of academia;
- The quest to achieve personal satisfaction in helping vulnerable families to meet their needs during crisis episodes;

Signing-up on a PhD programme for the pleasure of gaining intrinsic satisfaction as partly in the case of this study is supported by existing literature (Stein, 2008; Mueller, Flickinger and Dorner, 2015). Significantly, my pursuit of this PhD study has allowed me to grasp key concepts, theories and paradigms at each stage of the PhD journey. These core skills would become crucial in every aspect of my career in the field of higher education.

#### 1.4 Geographical and sociological context of the study

Ghana is a young lower middle-income country and predominantly inhabited by black African people. It has unique locales and lifestyle that require an insight into, for easy understanding of this research and its findings. It is also important to review the family systems and social lifestyle of Ghanaians to appreciate the manner in which family centred care is perceived and applied in the care of the severely injured child in the hospital.

Ghana is a sub-Saharan African country located in West Africa. It has a land area of 23 million hectares which lies between latitudes 4°45'North and 11°11' North, and longitudes 3°07' West and 1°14' West. The land stretch dimensions from south to north measures 522 miles and east to west is 355 miles. Located to the east is the Republic of Togo, Burkina Faso in the north, Ivory Coast on its west and the Gulf of Guinea is found in the south. Ghana, with the advantage of its location, has ports and harbours at the edges of the Gulf of Guinea (Nukunya, 2003).

Figure 1.1 Ghana, a sub-Saharan African country, and research context



*Sourced: Google image*

Accra, the capital city of Ghana, is one of the cities located in the coastal belt of Ghana (see Figure 1.1). Ghana's coastal ports serve as transportation means to all its neighbouring countries. Thus, goods and services from other countries transport by road to and from the harbours. This increases the number of heavy-duty vehicles traversing across the length and breadth of Ghana's roads, which also contributes to road traffic accident cases (Damsere-Derry et al., 2010). The road networks linking towns and cities have contributed to the transfer of accident cases from far and near to the cities for hospital care. However, there are other socio-cultural, economic and literacy factors which play decisive roles in people accessing healthcare in Ghana.

## 1.5 The socio-cultural patterns in Ghana

Ghana, formerly known as the Gold Coast gained its independence from the British colony in 1957. In 1960, Ghana became a republic nation with a one-party state in 1965. Many years after independence, Ghana witnessed episodes of political instability, which affected its socio-economic developments. Since 1992, Ghana has seen political stability although with changes in governments through presidential and parliamentary elections (Nukunya, 2003). It is currently estimated that Ghana has a population of 24,658,823 people, which 97.6 percent are indigenous people (Awusabo-Asare et al., 2013).

Although one government runs the nation administratively, Ghana is a multicultural society with poly-ethnic groups (Nukunya, 2003). There are eight major ethnic groupings by the similarities in the dominating languages spoken. These groups are Akan, Ga-Dangme, Ewe, Guans, Gurma, Mole-Dagbani, Grusi, and Mande (Awusabo-Asare et al., 2013). Table 1:1 shows the proportions of the ethnic group distributions as reported in 2000 and 2010 censuses in Ghana. It is also worth mentioning that among the eight major groupings are further subdivisions of smaller groupings with distinct cultural practices (Assimeng, 1999).



Table 1.1 Proportions of the ethnic groups in Ghana, as of 2000 and 2010

Ethnic Group	2000	2010
Akan	49.1	47.5
Ga-Dangme	8.0	7.4
Ewe	12.7	13.9
Guan	4.4	3.7
Gurma	3.9	5.7
Mole-Dagbani	16.5	16.6
Grusi	2.8	2.5
Mande	1.1	1.1
Other	1.5	1.4

Source: (Awusabo-Asare et al., 2013)

According to the 2010 population census, Ghana administratively divides into ten regions, and local governance occurs at the regional, districts and assembly levels. There are 197 districts. Table 1:2 presents the population densities of the regions from the year 1983 to 2010. The Greater Accra, one of the ten regions is the capital city of Ghana inhabiting 16.3 percent of the total population of Ghana. Accra being the capital, is the second highest populated urban dwellings in Ghana and the chosen region for this research. In Ghana, and all over the world, there is evidence of significant inequalities across geographical areas and socio-economic group, which affects people's access to healthcare services and consumptions (Vandebroek, 2013; Adjei and Buor, 2012; Jehu-Appiah et al., 2008).

**Table 1.2 Population density by region, 1984-2010**

Region	Land Area (km <sup>2</sup> )	Land Area (%)	1984	Population Density	
				2000	2010
Ashanti	24,389	10.2	85.7	148.1	196.0
Brong Ahafo	39,557	16.6	30.5	45.9	58.4
Central	9,826	4.1	116.3	162.3	224.1
Eastern	19,323	8.1	87.0	109.0	136.3
Greater Accra	3,245	1.4	441.0	895.5	1,235.8
Northern	70,384	29.5	16.5	25.9	35.2
Upper East	8,842	3.7	87.4	104.1	118.4
Upper West	18,476	7.8	23.7	31.2	38.0
Volta	20,570	8.6	87.0	109.0	136.3
Western	23,921	10.0	48.4	80.5	99.3
Total	238,533	100	51.5	79.3	103.4

Source: (Awusabo-Asare et al., 2013)

The literacy level of Ghanaians is estimated at 74.0% for the population aged 11years and older. About 67.1%, which forms the majority, can read and write in English and other languages, while 20.1% can read and write English only; about 53.7% read and write in one additional or more Ghanaian language. The female population recorded a higher increased in literacy level since the year 2000 than males. Despite this achievement, the literacy level of the male population is still higher than females. About 23.4% of the total population above three years and older have never been to school (Awusabo-Asare et al., 2013).

**Table 1.3 household heads by literacy, sex and locality of residence**

Literacy	<u>Total</u>		<u>Urban</u>		<u>Rural</u>	
	Male	Female	Male	Female	Male	Female
English only	20.0	19.3	25.0	23.4	16.6	14.6
Ghanaian language only	6.0	7.9	4.6	7.8	7.6	8.9
English and Ghanaian Language	51.9	40.3	58.0	47.2	45.1	32.1
English and French	0.4	0.3	0.6	0.4	0.2	0.1
English, French and Ghanaian language	0.9	0.7	1.4	1.1	0.4	0.3
None (not literate)	19.9	31.5	10.5	20.8	30.1	44.1
Number	8,330,530	9,062,325	4,374,237	4,912,496	3,956,293	4,149,829
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: (Awusabo-Asare et al., 2013)

Considering economic activities, Ghana has a mixed economy (Pollard, 2006). Predominantly, skilled agriculture, forestry, fishery, services, crafts and sales are primary occupations in Ghana. The recent population censuses (2010) estimated about 42.2% of the economically active population of aged 15years and above are skilled agriculture, forestry and fishery workers (Awusabo-Asare et al., 2013). Males form the majority (37.7%) of this workforce. Economically active female population dominate the service and sale industries, which covers about 21% of the populations' workforce. The remaining 15.2% are engaged in crafts and trade work. Females form the majority of the estimated 22.6% of the unemployed

population probably because women are considered more as homemakers than men (Awusabo-Asare et al., 2013).

**Table 1.4 Household heads by occupation and locality of residence, 2010**

Occupation	<u>All localities</u>		<u>Rural</u>		<u>Urban</u>	
	Male	Female	Male	Female	Male	Female
Managers	3.0	3.4	4.9	4.3	1.2	
Professionals	7.5	5.2	10.7	6.4	4.0	3.5
Technicians /associate professionals	3.1	1.2	4.9	1.6	1.3	0.7
Clerical support workers	1.7	1.5	2.8	2.3	0.5	0.4
Service/sales workers	9.8	35.1	15.9	45.8	3.4	19.1
Skilled agricultural forestry/fishery workers	43.4	29.3	15.5	10.7	73.1	56.8
Craft and trade related workers	16.3	13.4	23.7	14.5	8.4	11.7
Plant/machine operators assemblers	10.0	0.6	14.0	0.5	5.7	0.7
Elementary occupations	3.8	8.8	5.7	1.9	2.0	4.3
Other occupations	0.3	0.1	0.6	0.1	0.0	
New workers seeking	0.9	1.5	1.3	1.9	0.5	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: (Awusabo-Asare et al., 2013)

Religion, as used here relates to beliefs and practices associated with the supernatural. The people of Ghana are, known for religious practices at many different levels and in varied forms (Nukunya, 2003). Predominantly, 71.2 percent of the total population profess Christian faith, 17.6 percent Islamic religion and 5.2 percent African traditional religion. The remaining 5.3 percent may be practising other unknown religions or none at all (Awusabo-Asare et al., 2013). Additionally, there are other smaller gods such as ancestral influence, witchcraft, magic and sorcery (Nukunya, 2003). The worship of smaller gods although may be viewed on a smaller scale; it is perceived to influence people who do not practise it. Empirical evidence exists that religion (denominational affiliations) have influences on decisions regarding health-related issues among women in Ghana (Gyimah, Takyi and Addai, 2006).

**Table 1.5 Religious affiliation among the Ghanaian population: in the year 2000 and 2010**

Religion	2000	2010
Catholic	15.1	13.1
Protestant	18.6	18.4
Pentecostal/charismatic	24.1	28.3
Other Christian	11.0	11.4
Islam	15.9	17.6
Traditionalist	8.5	5.2
No religion	6.1	5.3
Other	0.7	0.8
Total population	18,912,079	24,658,823

Sourced: (Awusabo-Asare et al., 2013)

Culturally, Ghanaians (just as in other African countries) value the well-being of groups. As such, the people of Ghana mostly dwell in smaller units as families or slightly bigger units as households dwelling society (Awusabo-Asare et al., 2013). Symbolic social events are signified by families coming together to foster spiritual and physical bonds. Common culture practised by all ethnic groups in Ghana includes the celebrations of childbirth, puberty, marriage and death. Consequently, it is expectant of every member of the family to start a new family at some point in time to expand the family's lineage. The constitution of a family is, therefore, the most important ambitions and expectations of every young adult. It is therefore deemed crucial to discuss how the family is constituted in the Ghanaian culture and the duties and responsibilities of the family towards childcare.

## 1.6 Family systems in Ghana

There are two distinct family systems practiced in Ghana; the nuclear family and the extended family systems. The nuclear family system or the family of procreation comprises man as a father, woman as the mother and offspring (Nukunya, 2003; Assimeng, 1999). The extended family system or family of orientation locally referred to as a "*crowd*" comprises of more than two generations (Twumasi, 2005; Salm and Falola, 2002). The traditional family systems and gender relations are among the powerful social institutions, which affect the overall development and socialisation of the Ghanaian child. The family

practices in Ghana often reflect patterns of a particular extended kinship system referred to as lineage descent (Nukunya, 2003; Assimeng, 1999).

A lineage is a basic framework for the organisation and management of traditional society and complex relationships (Salm and Falola, 2002). People from a common lineage are linked to the same ancestral parents, often share common beliefs, religion and other characteristics. The lineage system governs and controls family resources, ensures social norms are preserved and perpetuated, and plays key roles in the rites and religious practices of the lineage. For example in Ghana, there are two major types of kinship descent systems: the patrilineal and matrilineal. The kinship system, which predetermines the ownership of children between parents, also influences family resource allocation towards the maintenance of the child. In the patrilineal system mostly practised in the northern half of Ghana, children are perceived to belong to their fathers, which implies that resources towards the children maintenance and care often lies on the shoulders of the father and his extended family. The matrilineal family system, on the other hand, observes a kinship relating to women. The children belong to women (mother) and critical decisions, and other crucial responsibilities towards children welfare are the responsibility of the brother (s) of the woman (mother) or the maternal uncles of the children (Nukunya, 2003; Assimeng, 1999).

The cultural practices of family systems in Ghana and the value placed on children influence the health and socialisation of children in the child-rearing process. Notably, in Ghana, it is believed that children are gifts from God or the

gods or could be a reincarnation of ancestors (Assimeng, 1999). Having children is, therefore regarded as a blessing regardless of whether one can care for the child or not. Childlessness, therefore, is treated as a curse, and the result of possible breaches of tribal taboos (Assimeng, 1999; Donkor, 2008). Therefore, in the traditional family setting, every adolescent hopes to become a parent; and parents, young or old, educated or not, employed or unemployed are responsible for raising their children (Macauley, 1974) with enormous support from the extended family. Within the formal milieu, the Ministry of Gender, Children and Social Protection, Ghana (MGCSPG 2015) defines the family as a group of people related by blood, marriage, law (in the case of adoption), common identity as well as lineage and ethnic group.

In accordance with the Ministry's position, it is presumed that all policies and legal frameworks concerning issues of the family are guided by the traditional and cultural norms, which recognise both the concept of nuclear and the extended family practice in Ghana. The duties and responsibilities of members of the family are predetermined based on the kinship type, gender and religious beliefs and practices of communities and families. Traditionally, in most cultures in sub-Saharan Africa, as pertains in Ghana, individual roles and responsibilities within the family are organised in a hierarchical order according to age, gender and status. Among these responsibilities are family caregiving, such as physical care (hygiene care, bathing, toilet training, grooming), nutritional care (choice of diet, cooking, feeding).



Often in the family, the parents are expected to provide financial resources and basic care needs for the children. However, there are roles based on gender specifically. Largely, men are regarded as heads of the family, who hold power and authority over women and children. They are expected to provide for the health and well-being of their wives and children. Wives, on the other hand, are supposed to obey their husbands' authority, care for the children and be responsible for domestic chores. These functions include the preparation of food for the family, personal hygiene practices, etiquette, toilet rules, economic activities, shelter among others (Nukunya, 2003; Assimeng, 1999; Macauley, 1974).

Regarding childcare, most societies in Ghana, however, delegate housekeeping duties and caring for the children to the woman, thus the female spouse of the family. Women by Ghanaian customs are mandated to feed the child from the day of birth until the child becomes independent averagely between ages six to ten years. Similar to the provision of the food, it is the mothers' duty to provide the growing child with protection from harm, clothing, comfort, direction and all other practical help that a mother can give. Where the family is well established and has more children, the mother could get assistance from older children, especially the female child, in caring for their younger siblings.

In situations of extended family systems, other females within the family assist in the care of the child. In the absence of the mother, the elderly females provide care to young children. In return, the elders are expected to be accorded honour

and respect by the younger people because of their age and life experiences (Salm and Falola, 2002; Falola, 2000). In view of this, women, in other words, mothers, are physically and emotionally closer to their children than their fathers are. Despite the possible assistance a mother gets from older children or the extended family, there is a common traditional belief in Ghana that a child needs a mother at all times (Nukunya, 2003; Macauley, 1974).

Alongside the cultures and customs practiced in Ghana, there are processes both external and internal that influence the traditional family systems and functions in modern societies in Ghana. The widely reported of such are colonisation, westernisation and urbanisation (Salm and Falola, 2002; Laird, 2011a). In contemporary Ghana, the nuclear family can be found especially in urban communities because of the influence of urbanisation and westernisation (Nukunya, 2003; Assimeng, 1999). Furthermore, other factors such as social change, education, economic activities of families and disease pattern have influenced families and the care and well-being of the child. Nevertheless, the fundamental necessity for every family to have children remains crucial.

There are indications that the kinship system faces challenges in contemporary times (Assimeng, 1999). It has been observed that unlike the pre-colonial days, families today will disregard reciprocal obligations and responsibilities to their extended relations. The educated parents, as so-called elites limit their responsibilities to their spouses and children. In most cases, any further extensions are limited to parents, siblings and their children. Furthermore, in the

search for greener pastures, both the elite families and unskilled youth are migrating to urban cities and thus distancing themselves from extended relations. These factors may have both positive and negative impacts on childcare.

Although women are increasingly playing active roles in an economic and political milieu, the societal expectations of the different domestic gender roles are acquired at a very early age. Ghanaians still hold the belief that regardless of a woman's level of education and nature of work, it remains their core responsibility to raise children, cook for the family and clean the house. Consequently, women tend to spend more time with their children than men, and this trend continues when children are sick and admitted to hospitals.

## 1.7 An overview of health and healthcare services in Ghana

The available statistic on Ghana's health indicators shows a steady but slow progress in disease eradication and control over the years (Ministry of Health, 2014). Table 1.6 provide the list of the disease burden for all ages in Ghana. The number of live birth per thousand is about 799.6, and a death per thousand is 209.5. According to the WHO assessment, life expectancy for both sexes at birth increased by four years between the periods of 2000 to 2012. The current available data shows that life expectancy at birth is 58 years and after age 60, it is 17 years. Thus, the rate of premature deaths among the population of 0-45 years is very high (PME 2007MOH/PPME, 2007). In 2012, it was observed that

Ghanaians lost up to the equivalent of nine years of healthy life due to diseases and disabilities (WHO, 2015a)

Table 1.6 Disease burden grouped by causes

Rank	Causes of disease conditions
1	Maternal, neonatal, nutrition
2	HIV, TB, malaria
3	Other non-communicable diseases
4	Cardiovascular diseases and diabetes
5	Acute respiratory infections
6	Unintentional injuries (RTAs, burns, fall, drowning etc)
7	Neuro-psychiatric conditions
8	Cancers
9	Chronic respiratory diseases
10	Musculoskeletal diseases
11	Suicides, homicides and conflicts

Source: (WHO, 2015a)

Regarding healthcare services, the Ministry of Health (MOH) is the largest organisation responsible for health care delivery in Ghana. As part of its mandate, the MOH seeks to enhance the health status of all people living in Ghana through standardised policy formulation, resource mobilisation, monitoring and regulation of health care delivery in Ghana. The MOH achieves objectives by working with different agencies under its umbrella. Health agencies who liaise directly with the MOH are the Ghana Health Service (GHS), Teaching hospitals, Christian Health Associations of Ghana (CHAG), National Ambulance Services, National Health Insurance Services and Food and Drugs Authority.

At present, health care delivery in Ghana is grouped under categories; the public health services mainly by GHS, private-for-profit (private individuals), private-not-

for-profit (mostly CHAG and University Hospitals) and traditional systems (traditional private practitioners) and Teaching Hospitals. Under the public healthcare institutions, there are ten regional hospitals, and several district level hospitals and clinics in Ghana (Bohmig, 2010). Administratively, these health facilities are directly and indirectly under the management of the central body, the Ministry of Health.

There are four Teaching hospitals geographically located in different cities in Ghana. These teaching hospitals often have several units and departments for managing various disease conditions. For these reasons, they serve as major referral hospitals in Ghana. The teaching hospitals also serve as training centres for all health professionals including nursing, which legitimises their operational excellence in medical care delivery. Furthermore, these hospitals serve as a major centre for most health research. The main characteristics of teaching hospitals in Ghana are that of semi to fully autonomous status as established by an Act of Ghana Parliament (Act 525). In line with their semi-autonomous status, teaching hospitals obtain part of their budget directly from the government and partly from Internally Generated Fund (IGF). This research took place in two tertiary/teaching hospitals, discussed in detail in section 4.2.

On the issue of human resources, there is a persistent nationwide shortage and unevenly distributed critical health staffs, such as doctors and nurses. The holistic assessment of the health sector report (Ministry of Health, 2014) shows that the ratio of doctor-persons population in Ghana is 1 to 10,000. The ratio of nurse-

persons population is 1 to 1,000. Although there seem to be high concentrations of the health professionals in the cities, the doctor-persons ratio in the capital of Ghana is 1 to 4,100, which is considered inadequate (Ministry of Health, 2014). The lack of coordination between training institutions and healthcare facilities has contributed to the persistent acute shortage in the key healthcare staff (Ministry of Health, Ghana, 2015). Among the essential aspects of FCC practice is staff coordination (Berman, 1991). Staff shortage, which is a potential consequence of poor staff coordination, is one of the factors that influence the quality of healthcare delivery to children, as well as effective practice of FCC concept (Berman, 1991; Coyne et al., 2011)

Currently, the national healthcare service is guided by the Health Sector Medium Term Development Plan II (HSMTDP II) developed between 2014 and 2017. Six key national health objectives or priority areas are enshrined in the HSMTDP II. These targets are to:

- Bridge the equity gaps in geographical access to health services
- Ensure sustainable financing for health care delivery and financial protection for the poor
- Improve efficiency in governance and management of the health system
- Enhance the quality of health services delivery including mental health services
- Enhance national capacity for the attainment of the health-related MDGs and sustain the gains

- Intensify prevention and control of non-communicable and other communicable diseases

There is evidence that clinical care services have improved over the years. Reports reveal that while there are increased numbers of hospital admissions, the number of in-patient deaths has decreased tremendously. The ratio of institutional deaths due to all causes improved from 27.8 death per 1000 in 2012 to 21.3 in 1000 in 2014. Thus, the evidence of improved performance in clinical care service (Ministry of Health, Accra, Ghana, 2015). This research contributes knowledge to the fourth national health objective, and thus, to professional practice, in order to improve the quality of health services delivery.

## 1.8 Hospital care for sick and injured children in Ghana

There is a scarcity of literature on the history of hospital care for children in Ghana. The little information available indicates that the institutional care for children in Ghana dates back to the colonial years when Ghana, then known as the Gold Coast, was one of the African colonies of Great Britain. Historical records indicate that Princess Marie Louise, the granddaughter of Queen Victoria of Great Britain, laid the first foundation stone for the first children's hospital in Ghana. It happened after the then Governor, Sir Gordon Guggisberg approved for the establishment of a children's hospital in 1915. The hospital, later named after the Princess, was completed and began operating in 1926, during the British colonial administration (P.M.L., 2017). Currently, the Princess Marie Louise

Children's Hospital (PML) in Ghana is a 74-bedded facility. From the time of its establishment to date, the focus of disease management has been communicable diseases and nutritional problems in children. At present, PML is a major referral centre for children's nutritional rehabilitation in Ghana (PML Biannual Report, 2013).

Since 2008, child health care delivery for the public sector has been placed under the Family Health Division of the Ministry of Health (Ghana Health Service, 2014). Under the Family Health Division, the Child Health Care Department has been placed under the same umbrella as Reproductive Health Care. As part of its mandates, the Child and Reproductive Health Department are to oversee all activities aimed to promote, maintain the optimal growth and development of children aged zero to eighteen years (0-18yrs).

Currently, the national programmes on health services for children are prioritised and categorised under three subdivisions, which are, children under five years (0-5yrs), school going age children (5-15yrs) and adolescents (10-19yrs). The overall national healthcare priority areas for children (Ministry of Health, Accra, Ghana, 2015) include the following:

- Neonatal health
- Prevention and management of nutritional problems
- Prevention and control of infectious diseases and injuries
- Clinical care of the sick and injured child
- Adolescent health



- School health

This research contributes to the body of knowledge relating to the fourth national priority of childcare, which focuses on the clinical care of the sick and injured child. There are very few hospitals in Ghana with facilities to manage trauma and injuries in children. Mostly children involved in different injuries depending on the severity may be cared for in the adult surgical units or at best, combined with other children with surgical conditions, an observation confirmed in the findings of this research (see chapter 6). The two largest tertiary referral hospitals in Ghana, where this research was conducted both have Paediatrics, Accidents, and trauma departments. However, there seems to be a lack of specialist facilities and model of care approach, specifically for the injured child and their families. For example, the 2012 annual report from one of this research site indicates that RTA cases for all ages are managed together by one unit; the Accident and Orthopaedic Unit. Although the annual report did not present a separate statistic of children involved in RTA, evidence revealed that overall, RTA is the top leading cases recorded for both children and adult recorded by the Accident and casualty Unit (see Table 1:7).

**Table 1.7 Top ten cases seen at casualty reception at the Korle-Bu Teaching Hospital, 2012**

Rank	Cases	No. of patients seen
1	Road traffic accident	4,767
2	Falls	2,102
3	Falls from height	1,952
4	Assaults	1,804
5	Foreign body(eyes nose and throat)	794
6	Burns	485
7	Dog bite	271
8	Trauma	123
9	Gunshot	51
10	Stab wound	27
	Total	12,376

Source: Korle-Bu Annual Report (2012)

**Table 1.8 statistics of patients seen at the casualty department from 2012 to 2016**

Year	Outpatient cases	Admissions
2012	16,555	726
2013	14,531	793
2014	12,890	816
2015	10790	439
2016	9,553	900

The report shows a persistent increase in casualty cases over the years with the exception of 2015 where a significant decrease in admission cases was recorded. This presupposes that RTA, being the one cases seen at the accident centre is the leading causes of admission among both adult and children. The 2013 report of the Korle-Bu teaching hospital recorded a constant congestion at accident and casualty units where both adults and children are nursed together (Korle-Bu Teaching Hospital, 2013b; Korle-Bu Teaching Hospital, 2013a). Furthermore, successive reports revealed that the conventional units of care for injured children following emergency care have deteriorated as a result of overuse and work pressure.

The health professionals who care for the injured children in the hospitals are mainly consultant (often the team leader) orthopaedic surgeons, physicians mostly referred to as doctors, pharmacists, nurses of various ranks, ward orderlies or porters and ward assistants. Others include physiotherapists, nutritionist and dieticians. Clinical psychologists are also professionals who provide care on demand. Evidence suggests that there is a constant lack of an adequate number of critical staff such as doctors, nurses and nursing assistants for the care of the injured child in the hospital (Korle-Bu Teaching Hospital, 2013b; Korle-Bu Teaching Hospital, 2013a; Norman et al., 2012).

The cost of clinical care (another important area, although not a focus of this research) can be very influential in care decisions of the sick child in hospitals in Ghana. The trauma and emergency unit is the first point of call for most sick and injured children seeking hospital care. By right, all accident and emergency cases including that of children would receive emergency medical care without demand for a fee for up to 48 hours. Further medical costs may cover direct and indirect care services. Direct medical cost, which is subsidised by the government, covers mostly medical consultation, bed, feeding, and medication, treatments such as laboratory investigations, surgery, Plaster of Paris (POP), and wound dressing. Some prominent indirect cost of medical care includes monies families spend for food, beverages, travel cost and monies given as tips to some hospital staff for prompt and quality care (anonymous report).

The sources of funding available to individuals for health care include NHIS, private health insurance, special taxes and individual persons and families out of pocket pay. In the case of RTA victims, further negotiations often get the drivers and car owners to support funding medical cost. One major finding from this research is funding challenges of medical care (see section 5.6.5).

Common to almost all hospitals, there is no purposely-developed system and structure for the support and care of the family and relatives of the sick children. Currently, in Ghana, there seems to be little research regarding the care of the injured children and their families. This claim is evident in two consistent annual reports of the largest national referral teaching hospital (Korle-Bu Teaching Hospital, 2013b; Korle-Bu Teaching Hospital, 2013a), and one of the study sites for this research. This study, therefore, explored the perceptions and practices of families and professionals in the care of the injured and hospitalised child. The study also contributes to the body of knowledge related to the clinical care of the sick and injured child, the fourth objectives of the national priority for children in Ghana.

## 1.9 Thesis structure

The remaining chapters of the thesis are organised as follows; Chapter two discusses theoretical concepts, which recognises the care needs of the sick child in hospital, the burden on families caring for hospitalised children, and ways health professionals work with families to give care to children in hospital. The

chapter concludes with the research guiding objectives, which enabled the exploration of the FCC concept within the Ghanaian context. Chapter three details the research methodology. The philosophical underpinning of this study, which elaborates the ontology, epistemology and methodological decisions of the study, outlined. In accordance with the study's philosophical stand, the selected research methodology guided the research method.

Chapter four presents the research method and procedures. The description of the study site, design and procedures in the study were detailed in this chapter. Participant sampling, recruitment procedures and total sample size are presented. The chapter further outlined data gathering method and data analysis strategy of the study. The process of applying to ethics review committees and ethical approvals gained for the research are described. Other ethical issues in relation to participant safety and confidentiality considered in the research are detailed.

Chapter five and six present the findings from data gathered as study results. Interviews were managed with the NVivo software, and emerging categories and sub-categories presented. Chapter seven details the discussions of findings in relation to the existing literature. The findings and discussions, which informed a conceptual framework, are presented. Chapter eight, the concluding chapter presents the summary of key findings, recommendations and conclusion of the study.

## 1.10 Conclusion

This chapter highlighted the carnage of RTA, which forms one of the top ten leading causes of death and hospitalisation of both adults and children in Ghana. Besides, the hospital care of the injured child remains one of the neglected areas of clinical care that requires exploration in Ghana. The value of children within the sociocultural context of Ghana and the care responsibilities of their families suggest that families are affected by the hospitalisation of the injured child. Hence, this study explored the perceptions of parents and health professionals on FCC for children hospitalised through RTAs. The next chapter explores the theoretical perspectives of FCC within the literature domain.

## 2 Chapter 2: Theoretical perspectives

### 2.1 Introduction

This chapter reports on the literature review done in areas related to hospital care for sick children and family centred care. The first section of chapter outlines the appropriateness of reviewing the literature prior to data gathering in grounded theory methodology. Next, the approach to searching the literature is discussed. The chapter continues with an outline of the thematic areas relating to the intended research objectives. Finally, the chapter ends with the research purpose, question and objectives.

This review adopted the narrative literature review approach. Narrative reviews describe and discuss the state of science on a specific area from a theoretical and contextual point of view with less emphasis on structure for gathering and presenting evidence (Brandon et al., 2018). Although systematic literature review is judged the best review strategy (Goodall, Marples and Roberts, 2013), other credible approaches such as the narrative review used for this study become useful and appropriate amidst a number of factors. In this review, a careful consideration to the research context, where limited knowledge exists on the research topic was a deciding factor for adopting the narrative literature review.

## 2.2 Engaging with the literature in grounded theory methodology

The founders of grounded theory methodology, Glaser and Strauss (1967) advised against engagement with literature prior to data collection and analysis (Glaser, 1992). This ideology mimics the critical realists' stance (Harris, 2015). It ensures that researchers approach the data collection and analysis devoid of preconceived perspectives on the topic researched. Followers of this approach believe that a prior knowledge on topics researched present a risk of forcing data to fit existing theories. Instead, they suggest that an emerged theory be discussed in the domain of existing literature after the discovery (Glaser, 1998).

In contrast to the critical realist views, contemporary grounded theorists justify reviewing the literature at the onset of the research (Birks and Mills, 2011). These include the need to show evidence of the gap in knowledge on the topical area to merit the conduct of the current research, to meet research grant criteria and to adhere to standards to gain ethical approval. Furthermore, Harris (2015) suggests that the mere experience of practitioners in the area under investigation forms part of the sensitisation prior to the research. In agreement with Harris, my background as a professional nurse educator, I have to an extent familiar knowledge with the research area and context. Also, in order to effectively analyse data, I needed a degree of theoretical sensitivity to the topic area. Hence, the aim for the literature review in this research as a novice researcher was to develop of theoretical sensitivity. In line with the suggestions of Walls et al. (2010), theoretical sensitivity requires open mindedness and reflexivity in the



conduct of data collection and analysis, and as well, the application of principles of constant comparative analysis to arrive at the emerging theory from data. Remaining open minded in this research resulted in the discovery of the two concepts (see chapters 5 and 6) other than the intended family centred care explored. The reflexivity employed in this research is also detailed in sections 8.2.1 and 8.2.2.

### 2.3 Strategies used to review the literature

The preliminary literature search strategy was broadened to capture wider scope of the concept beyond the Ghanaian and African contexts. The date span for searched resources extended beyond the recommended ten years period in academia. This formed part of the effort to understand the historical perspective and the evolutionary phases of the concept FCC. Mainly, two different libraries', DMU and University of Ghana, resources were used. Electronic resources from specific databases recommended for nursing, and midwifery including CINAHL Plus, British Nursing Index, Scopus, Cochrane Library, Science direct, Medline (PubMed), ASSIA, and EBSCO were explored. Google scholar was occasionally useful as well. Grey literature sampled included the print media, quarterly and annual reports of the health institutions where this research was conducted. Other reports on childcare in Ghana and other countries were consulted. Supervisors' recommendations and snowballing from references of useful articles also featured. Relevant information on the subject investigated was sourced from

multiple materials including books, published articles from journals, and grey literature.

Keywords were crucial to identifying the relevant resources for the literature search. Among the them are parents, family, sick child, injured child, hospital care, involvement, participation, health-professional, partnership, care, collaboration, Ghana, sub-Saharan Africa, and family centred care. The search combined these words to sample relevant research articles from the nursing oriented databases.

The initial search generated over three thousand (3000) possible articles. However, these were filtered with features on the databases such as available full texts, published materials in English language and peered reviewed articles. Furthermore, duplicate materials were removed and nearly three hundred (300) research articles were retrieved. The titles of the 300 articles were further scrutinized for relevance to the research question and objectives. The abstracts of these articles were scanned and read to select the relevant ones. Essentially, articles from the worldwide literature, relating to hospital care for the sick and injured child, FCC, and family involvement were included. Such articles focusing on adult care in hospitals were excluded. Articles that focused on other specific settings such as FCC for home based care and those which focused on a particular disease conditions such as chronic conditions, and not explicit on the family's role in care were also excluded. About 35 of the articles where identified useful, read thoroughly, analysed and used for this writeup.

Most of the documents retrieved were mainly from Australia, Ireland, United Kingdom, United States of America, Canada and other European countries. Only a handful of articles from African context (Roets, Rowe-Rowe and Nel, 2012; Saloojee et al., 2009; Söderbäck and Christensson, 2008; Jardien-Baboo et al., 2016) such as South Africa and Mozambique were located. Surprisingly, the search could not find any research studies on FCC from the Ghanaian context, which is an evidence of a knowledge gap needed to be explored.

Many of the articles focused of the evolution of the FCC concept in the different cultures and context (Alsop-Shields and Mohay, 2001a; Van der Horst and Van der Veer, 2008; Palmer, 1993; Shields and Nixon, 2004; van and van, 2010; Jolley, 2007; Jolley and Shields, 2009). Different contextual connotations were assigned FCC (Neill, 1996; Casey, 1995; Kristensson-Hallstrom, 2000; Coyne, 2008; Hutchfield, 1999). The debates about its applicability in the different care settings also trend in the literature. Several studies were focused on FCC in the Intensive Care Units (ICU) (Ebrahim, Singh and Parshuram, 2013; Wigert, Hellström and Berg, 2008; Wigert, Berg and Hellström, 2010). A few articles reported its applicability in emergency department (Boudreaux, Francis and Loyacano, 2002; Moreland, 2005; Parkman Henderson and Knapp, 2006; Egging et al., 2011; Pruitt et al., 2008). Others reported it application in operating theatres (Kisby, 2016; Shields, 2007). It was realised that there seems to be no empirical evidence on FCC for children with RTA and receiving care in the main paediatric surgical unit, hence, the need to explore FCC children hospitalised through RTA.

This literature review account is presented based on the thematic areas identified in the 35 most relevant articles related to the objectives of this research. These are reported under the following headings;

- The era of hospital care for children before evolution of family centred care,
- Family visitation to children in the hospital,
- Family involvement, family partnership and participation
- Family centred concept.

## 2.4 Before the evolution of family centred care

In high-income countries, hospital environments before the 1920s were friendly and pleasant places for children (Jolley and Shields, 2009). Health professionals were uniquely responsible for caring for sick children physically and emotionally, almost certainly holding the notion that parents in the past were not educated, and hence ignorant of the needs of their sick children. This promoted the admission of sick children to hospitals for many days and weeks without their parents (Cuttini et al., 1999). Children from poor background were even admitted to hospitals at Christmas with the intention to give them food and the opportunity to have fun with nurses and other health professionals (Jolley and Shields, 2009). Commenting on this practice, Jolley and Shields (2009) described children's nurses then as assuming supporting roles than just a professional duty to the sick child. During this era, sick children were described as the protective properties of the professionals because they were often isolated from families (Palmer, 1993).

The perspectives and practice of the hospital care for children, however, changed in the later years after the 1920s to the end of World War II. The outbreaks of infectious and deadly diseases in post World War II merited new approaches and strategies to medical interventions to curb disease spread and to eradicate preventable ones. Thus, efforts to make the hospital safe were the priorities of health institutions. Knowledge in the mechanisms of infectious diseases and its control among nurses and hospital staff came under scrutiny in the post-World War II era (Jolley and Shields, 2009). Among the strategies introduced included the reduction in physical contact with health professionals, children and their parents.

Parents were perceived as potential sources of infection to the hospitalised child during this period (Davies, 2000). In addition, there were beliefs that nurses were better caregivers to the sick child than their parents, and that children settle more easily in hospitals without interference from their parents (Palmer, 1993). Furthermore, the introduction of isolation techniques of the disease-infected child deepened (Van der Horst and Van der Veer, 2008). The motherly duties of nurses were relegated to the background and the professional's closeness to the sick that children traditionally enjoyed in hospitals diminished (Irlam and Bruce, 2002).

During the first half of the 20<sup>th</sup> century, children spent much longer periods in hospitals often being treated for infectious diseases (Davies, 2000). Some authors cited children spending as long as two years in hospitals without the presence of their parents (Wood, 2008). Furthermore, parents were required to

bring their sick children to the hospital, leave them in the total care of the nurses and collect them after recovery. No visiting was allowed from parents (Davies, 2000). It, therefore, became the norm that health professionals channelled their energies and resources towards preventing disease outbreaks, the therapeutic goal of the care systems. These practices portrayed nurses as strict, unfriendly and ardent implementers of institutional rules and governments guidelines (Mikkelsen and Frederiksen, 2011). Nurses were viewed as inhumane and affectless; with resultant adverse effects on the sick children. Consequently, children became fearful of the hospital environment. The psychological and emotional wellbeing of the sick child in the hospital became a great concern to societies. It was an era described as professionally centred health care (Ahmann, 1994b).

Increased interest in the exploration of the needs of hospitalised children gained ground through greater awareness about the effects of child separation and maternal deprivation. Earlier research on the consequences of child separation from families received keen interest in the 1930s onwards. The likes of John Bowlby, James Robertson and wife Joyce Roberson, Freud, Spitz, Harlow, Bakwin and Goldfarb were individuals whose works on the effects of separation of children from their parents gained wide publicity in the 1930 and 1960s (Bowlby, 2012; Bowlby, 1973; Bowlby, 1969)

In the UK, John Bowlby, a theorist, scientist, and crusader, between the first and second World Wars, studied the effects of maternal deprivation on the character

formation of children (Bowlby, 1973; Bowlby, 1969). Bowlby found that children who were separated from their mothers over a prolonged period as a result of hospitalisation developed affectionless characters later in life. His findings suggested that children between the ages of six months to three years were the group most affected by maternal deprivation (Bowlby, 1973) Bowlbys' later works on children separated by wars in Europe gained prominence, which grounded his theories of attachment. In addition to the works of Bowlby, James Roberson and his wife Joyce Robertson assisted to propagate Bowlby's work among the professionals, policymakers, and the research community. The motivation of the couple followed after they noticed a change in the behaviour of their hospitalised child. With the use of films and pictures, crusades were staged to sensitise the public on the effects of hospitalisation on children (Alsop-Shields and Mohay, 2001a; van and van, 2010; Jolley, 2007).

Further studies conducted in the 1940s supported the ill effects of hospitalisation on children. For example, Lowrey (1940), a British psychiatrist studied the pattern of child development and integration of personality of children placed in foster homes. Lowrey found that children who were isolated from their families and placed in care institutions developed aggressive and hostile behaviours. Such behaviours included excessive crying, stubbornness, attention-seeking behaviours finger sucking and difficulties about food. His conclusion was not supportive of institutional care for children.

Elsewhere in the USA, Bakwin (1942), cited by Van and Van (2008), a paediatrician observed the pattern of weight gain among small children in the

New York's Bellevue Hospital. The causes of high mortality rate among the children were attributed to malnutrition and infection. This necessitated barrier nursing care, such as smaller cubicle isolation care, mask and hood wearing and the prevention of parents' visitation. Bakwin observed that strategies for both infection control and the treatment of malnutrition had no significant impact on the child mortality rates. Moreover, children only gained weight after they were discharged home. Thus, the findings of Bakwin (1942) echoed the ill effect of separation of children from their families.

Goldfarb (1944), also a psychologist studied the care of Jewish children placed in a foster home in New York, USA. His findings supported that of Bakwin that children who experienced institution care developed similar personalities such as lack of inhibitions, control, and apathy of personality. Goldfarb identified three main features in children treated in institutions. These include the absence of stimulation, the lack of psychological interaction and a reciprocal relation with adults, and the lack of formal identification (Goldfarb, 1944).

In Australia, Spitz (1945), a psychoanalyst studied the relationship between mother and child and depression in children. Spitz was famous for his discovery of the term "hospitalism," which refers to the morbid conditions of the hospital environment after a prolonged confinement. Spitz further described a psychiatric depressive syndrome, which children suffered as a result of a loss of a loved object. Spitz referred to this depressive condition as anaclitic depression in children. His conclusions also supported a constant interaction between the child



and mother or a mother substitute for the normal growth and development of the child (Spitz, 1945).

There seems to be no documentation related to the institutionalised care of children in Africa during the first and second World wars. This suggests that the care of sick children in Africa was the responsibilities of families and children were cared for at home or as directed by their colonial masters. As mentioned under section 1.8, Ghana is the first African country to gain independence from the British government. The first children's hospital in the country was built in 1926 and managed by the British government. Available evidence indicated that similar to the purposes of children's hospitals in the UK during the 1920s, the Princess Marie Louise Children's Hospital (PML) in Ghana (then Gold Coast) was managing infections and malnutrition in children. This presupposes that the principles and concepts of childcare in Britain were transferred to the then children's hospital in Ghana. It is therefore not surprising that most childcare institutions in Ghana still practice strict visiting regimes in children's hospitals as was the norm during the period of 1920 to 1950s. There seems to be no evidence of studies on maternal deprivation or child separation recorded in Ghana during the years when such active studies were conducted in the UK, USA, and Australia. Also, there is no evidence related to parental interest in participation, involvement nor collaboration post-Ghana's independence in 1957. However, the literature reported on different phases of the different approaches to the hospital care of the sick across the globe, and this is highlighted in the next section.

## 2.5 Changing trends in visitation to children in hospitals

Active family visitation to children in the hospital resumed in the early years of the 1950s. This practice began in the UK as one of the achievements of the British government appointed Platt committee in 1959 and parents' pressure group, the National Association for the Welfare of Sick Children in Hospital (NAWCH) (Palmer, 1993). Although family visitation to the sick child began with many hesitations on the part of nurses, parents were eventually allowed few hours of different visits a week. Subsequently, it increased to daily visits and several hours in the day until at a point, a mandatory maternal presence during the sick child's stay in hospital was implemented (Alsop-Shields and Mohay, 2001a; Palmer, 1993; Palmer, 1993; Shields and Nixon, 2004).

The compulsory maternal presence with the sick child in hospital was referred to as care-by-parent (Darbyshire, 1995). This ensured that parents were admitted together with their sick children to the hospital. The parents were responsible for the care of their sick children, as well as the documentation of activities done daily for the child in the hospital. Nurses acted as supervisors and gave guidance to parents. This model, although praised by some segments of society, nurses held the view that parents were encroaching on their profession (Bruce et al., 2002).

Health professionals' attitudes towards families of hospitalised children in Canada in the early to mid-20<sup>th</sup> century mirrored similar practices in the UK (Young, 1992). For example, Young (1992) reported that public visitation to sick

children at the Hospital for Sick Children, Toronto began in 1935. Parents were given only one hour on Sundays to visit sick children in hospitals. The practice of restrictions placed on families continued until 1975 when most hospitals and children units allowed unlimited visits by the family to the sick child. However, Young (1992) reported that the change in nurses' attitudes at the oldest Canadian children hospital was slower than expected. This was attributed to factors such as entrenched beliefs in medical science, which outweighs key psychological findings on the effects of child separation from their parents. Furthermore, it was observed that nurse educators had minimal influence on clinical practice, which suggests a sense of division in the nursing fronts. These contributed to the reduced powers of nurses' ability to effect the much anticipated change in the practice of family visitation to the sick child in Hospital for Sick Children in Toronto (Young, 1992).

There is limited knowledge within the literature domain about Ghana regarding changes in practice of visitation to children in hospitals. It is therefore uncertain as to what changes occurred in child healthcare practice in the past decades. However, elsewhere, there were different concepts of childcare and visitation practices such as the concept of parental involvement, participation and partnership.

The characteristics of parental involvement reported by many include unrestricted visiting hours, rooming-in, and parents feeding and maintaining physical hygiene of their children (Neill, 1996). Other studies reported that parents wanted to be

by their hospitalised children without necessarily playing any significant roles (Ebrahim, Singh and S. Parshuram, 2013; Foster, Whitehead and Maybee, 2010). Parents argued that they help provide the observational roles that nurses play for sick children. Parental involvement was applied differently by different hospitals according to nurses' discretion and understanding of the parent involvement concept. In a study conducted in Sweden, Ygge (2007) reported that nurses identified that their ways of communication with parents were essential to clarify parental roles, to create a positive environments and to support parents. It was largely perceived that passing of information to some parents was enough; although others were appealing to be part of the decision-making processes involving their child's care. This trend is associated with increased educational level of parents.

The current literacy level in Ghana is about 67.1%, which consists of the population who could read and write in English. However, in Ghana, one could argue that learning or wisdom is not only through the formal educational system. People learn in various ways and also acquire knowledge that in their capacity can sustain them through life. In Ghana, there seems to be growing indications that parents of the sick children want to get involved in their childcare (Affram et al., 2008). The extent to which parents would want to be involved is one of the many questions the study seeks to answer.

Partnership with parents and parental participation were two other terminologies used interchangeably to describe one other model, which emphasised on

parents' participation in the care of their sick child (Vasli and Salsali, 2014; Power and Franck, 2008; Pongjaturawit et al., 2006). This concept has received attention and gained popularity since the 1980s as a result of the political impact and organisational changes to health management in the United Kingdom and other Western countries. Partnership as a childcare framework was mainly advocated for children with cancers and other chronic and terminal conditions (Ygge and Arnetz, 2004). To that end, Ygge, Lindholm and Arnetz, (2006) and Casey (1995) developed a partnership model, which illustrated how parents and nurses care to complement each other. The model recognised the health needs of the sick child, which requires assistance to achieve effective functioning.

Casey (1995) advocated that nurses must support parents to give care to a sick child. The nurse alone should give this care in the absence of parents. Partnership or participation observes a level of equality between nurses and parents. This demands equal respect and appreciation. It also gives room for negotiations of care between nurses and parents (Coyne and Cowley, 2007). This model may be well suited to trauma patients as often; they progress from acute through chronic to rehabilitation stages of medical care. A prolonged relationship between parents and health staff should require partnership. However, an equal degree of knowledge and agreement on the same or similar issue is necessary for both parties effective participation (Callery, 1997). The question about the partnership model as being effective should be considered for the Ghanaian context; especially since some nurses in Ghana still hold the views that most

patients and relatives are ignorant of the care they receive and their rights to these care (Gold et al., 2013a).

There are also the perceptions that nurses, medical doctors and other health professional are perceived higher in status and will not come down to the level of the patient (Coyne et al., 2011; DeMaso and Simona Bujoreanu, 2013). In a combination of the earlier factor stated, it would be complex deciding on one model without exploring the views of major stakeholders in paediatrics health care in Ghana. Varying views and perceptions may lead to components of the different models linked together to work in the context of Ghana. A combination of any part of these models that work well within any context is supported by family-centred care (Coleman, 2010b).

## 2.5 Family centred care concept

The Family-Centred Care (FCC) concept is the most recent terminology used to describe the collaborative effort between health staff and families of sick children in hospitals (Coyne et al., 2011). Although the concept has been debated for several decades (Coyne, 1996) and has gained, international recognition as one of the best practices in paediatric healthcare, recent evidence suggests that the debate about the concept is still ongoing (Mikkelsen and Frederiksen, 2011). These include the best definition of the concept, different perceptions of parents and health staff, the practicability and evaluative strategies to measure the

effectiveness in its application in the hospital across many countries, including the western countries where the concept evolved.

Hutchfield (1999) identified about ten different meanings assigned to the FCC concept. For example, the FCC is defined as a holistic care approach (Stower 1992), a philosophy that supports parents in their caring role (Gill 1993), a basic tenet of paediatric nursing (Nethercott 1993), care-by-parents and parents professionals collaborating (Evans 1994). The others were FCC viewed as an opportunity for parents to care for their hospitalised child under supervision and to maintain family roles (Odle 1988, Brunner and Suddarth 1986). To minimise the trauma of hospital stay and to allow an independence and quality of life that would otherwise be impossible (Robbins 1991). To recognise the family as central in the child's life and lastly, a partnership that supports parents in their central caring role (Ahmann 1994). In her analysis, Hutchfield (1999) identified two emerging views in the different definitions of FCC. The first is those that present a holistic view of the child and family collaboration efforts, and, the other, which reflects a more functional and less collaborative effort. Hutchfield (1999) invites readers to join in the ongoing debate, which could enable others to do analysis and determine which of the definitions fall under her two broad identified areas.

Mikkelsen and Frederiksen (2011) also echoed the lack of consensus on the definition of FCC concept. Their findings revealed that there are different meanings and understanding people assigned to the FCC concept. In their view, FCC was viewed by many as a set of principles that were identified by Shelton et

al. (1987) (see table 2.2). They also identified four definitions reflecting different perspectives on the concept. Mikkelsen and Frederiksen (2011), however, advanced on the works of Hutchfield (1999) to identify a continuum definition, which emphasize the autonomy and equality between parents and health professionals (see table 2:1). Other current existing definitions of the FCC are presented in table 2:1.

**Table 2.1 Definitions of Family Centred Care**

Author	Concept Definition
NCFPP (2017)	Family centred care is that which assures the health and well-being of children and their families through a respectful family-professional partnership. It honours the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centred Care is the standard of practice which results in high-quality services.
PFCC (2017)	Patient-and family-centred care is working “with” patients and families, rather than just doing “to” or “for” them. Patient- and family-centred care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings. In patient-and family-centred care, patients and families define their “family” and determine how they will participate in care and decision-making. A key goal is to promote the health and well-being of individuals and families and to maintain their control.
Mikkelsen, Frederiksen (2011)	FCC is the professional support of the child and the family through a process of involvement and participation, underpinned by empowerment and negotiation. FCC is characterised by a relationship between healthcare professionals and the family, in which both parts engage in sharing the responsibility for the child’s health care.

Moving on to the debates on core components of the FCC, Coyne et al. (2011) in their study conducted among nurses in Ireland identified five major core components of FCC. These include family involvement, working in partnership, negotiating care, delivery of high quality care and multidisciplinary approach. According to their findings, nurses perceived family involvement as the central component of FCC. In partnership efforts, the role of the nurse is to encourage



and empower parents to participate in non-medical care. The nurse also perceived communication and negotiation of care as central components of FCC. A multidisciplinary approach to care, which the nurses in Ireland considered as key in promoting FCC, were also perceived as essential to the delivering of the high quality of care perceived. According to the nurses in the study, high quality of care aims to reduce stress, anxiety, effect of hospitalisation for both child and family (Coyne et al., 2011)

Negotiation of care as one of the major components of FCC featured in many studies. For example, Corlett and Twycross (2006), Young et al. (2006b), Young et al., (2006b) Callery and Smith (1991) and Young et al.(2006a) were among the many authors whose works have contributed to the dimensions of negotiation of care between parents and health professionals in the hospital. Callery and Smith (1991) defined negotiation as the process applied by nurses to agree on the acceptable parental behaviours with parents. Although subsequent studies have concurred to this definition, evidence suggests that care negotiation is one of the difficult components to achieve in practice. Young et al. (2006b) conducted a study among parents in Australia to understand their perspectives on the role of negotiation of care for hospitalised children. The majority of parents in their study were unsure of the care roles expected of them. Although parents commended the idea of negotiation, they reported no evidence of negotiation between clinicians. Parent active participation increased with increasing length of hospital admission (Young et al., 2006b).

Communication as a component of FCC always surfaced in the literature alongside negotiation (Ygge, 2007; Casey, 1995; Young et al., 2006b; Young et al., 2006a; Butler, Copnell and Willetts, 2014; Aggarwal et al., 2009; McCann et al., 2008). For instance, Aggarwal et al. (2009) observed that irrespective of location and culture, effective communication and role negotiation between professionals and parents are among the major components of FCC. Young et al. (2006b) reported that almost all the parent participants in their study conducted in Ireland viewed information about their child's care as the highest priority for parents. Thus, parents prioritized and valued effective communication with hospital staff. McCann et al. (2008) also conducted a quasi-experimental study among nurse of which 69 nurses participated. Their findings revealed that a negotiated care tool compelled nurses to include parents in decision-making, encouraged parents to ask questions about their childcare and they invited the extended families to participate in care with parental approval. According to the findings of McCann et al. (2008), the negotiated care tool raised the staff's awareness of the importance of effective communication and negotiation of care with parents in acute settings.

Table 2.2 Elements of childcare and corresponding evaluative items

Elements of FCC	Evaluative items
1. Recognizing the family as the constant in a child's life	1. Family as the principle context for the provision of a child's healthcare
2. Facilitating parent–professional collaboration at all levels of healthcare	2. Promoting and utilizing parent–professional collaboration and partnerships
3. Honouring the racial, ethnic, cultural, and socioeconomic diversity of families	3. Respect for family diversity
4. Recognizing family strengths and individuality and respecting different methods of coping	4. Recognizing the strengths and capabilities of families
5. Sharing complete and unbiased information with families on a continuous basis	5. Recognizing different methods of family coping
6. Encouraging and facilitating family-to-family support and networking	6. Complete sharing of all relevant information with families
7. Responding to child and family developmental needs as part of healthcare practices	7. Promoting parent-to-parent and family-to-family support
8. Adopting policies and practices that provide families with emotional and financial support	8. Attention to the developmental needs of children and families as part of healthcare delivery
9. Designing healthcare that is flexible, culturally competent, and responsive to family needs	9. Recognizing and responding to family emotional needs
	10. Recognizing and responding to family financial needs
	11. Flexible delivery of healthcare to children and their families
	12. Culturally competent delivery of healthcare
	13. Recognizing and responding to family-identified needs

Source: (Foster, Whitehead and Maybee, 2010)

Roles and expectations of both parents and professionals is another aspect of the components of FCC widely investigated. Activities of daily living (ADL) are mostly identified as roles expected and performed by parents (Stuart and Melling, 2014). In other studies, ADL was perceived to be negotiated in care (Coyne et al., 2011). Ames, Rennick and Baillargeon (2011) studied perceptions of parental role among a heterogeneous group in paediatric intensive care unit at a Canadian tertiary hospital. The first of three themes, which emerged was “being present

and participating in child care.” Parents described their presence and participation in relation to their physical presence and ability to provide comfort, to play an active role in the care and to provide reassurance to their child. Kristensson-Hallstrom (2000) also reported similar findings from both parents and health professionals’ perspectives. According to Kristensson-Hallstrom (2000), increases in parental role uptake was progressive and directly related to increase in length of stay in the hospital.

Regarding the list of roles, Stuart and Melling (2014) and Paliadelis et al. (2005) in separate studies identified some sets of traditional roles nurses expect from parents and of which parents agreed to perform. These included staying with the child to provide soothing and comfort, feeding, meeting the child’s elimination needs, accompanying the child to diagnostic centres and the theatre, entertaining the child, as well as updating and advising health professionals on the progress of the child’s condition. In both studies, it was observed that participation in roles classified as technical or advanced nursing care occurred following instructions and supervision.

Concerning how parental roles were assigned, Ygge (2007) and Paliadelis et al. (2005) explored the perceptions of nurses on parental involvement in hospital care. Both authors identified as part of the duty of the nurse, the requirement to clarify parental roles. Participants of both studies were paediatric and newly graduated nurses, who held the same view; that is the duty of nurses to identify and assign the roles expected of parents in hospitals. Ebrahim, Singh and S.

Parshuram (2013) conducted a study in a paediatric intensive care unit and reported a high score rating of parental satisfaction and involvement. Although the study failed to establish the association between parental presence with satisfaction and involvement, parents' overall scores for involvement and satisfaction were high.

Irrespective of the evidence that the practice of FCC in paediatric settings is common in several contexts, there are also reported challenges of the practicability of the concept's practice even in the UK (Finlayson et al., 2014) and across other context (Kristensson-Hallstrom, 2000; Coyne, 2008; Uhl et al., 2013). Paliadelis et al. (2005) conducted a study in two regional hospitals in New South Wales, Australia. The findings revealed that the implementation of FCC in practice was problematic. Therefore, the use of clinical practice guidelines was suggested and developed for a more consistent application of FCC in that context. Uhl et al. (2013) carried out a similar study among parents of discharged children who experienced FCC at the paediatric unit and three themes were identified. These were apprehending the reality, engaging adversity and advancing forward. These categories, in narration depicted barriers to FCC practise in the NICU environment.

Few studies have reported on the FCC practice in the African context (Roets, Rowe-Rowe and Nel, 2012; Saloojee et al., 2009; Söderbäck and Christensson, 2008; Jardien-Baboo et al., 2016). For example, Roets, Rowe-Rowe and Nel (2012) conducted a study among mothers of children in intensive care units in

South Africa. The findings identified fifteen stressors of mothers caring for their children in the hospital; such as medical procedures on the child, child's appearance, inadequate and conflicting information, child suffering pain, parents changed roles and environmental factors. The others are fear of death, helplessness, separation from child (physical and emotional), the nature of the onset of child's condition, separation from other families and the numbers of staff involved in childcare. Roets, Rowe-Rowe and Nel (2012) recommend the implementation of the COPE (Creating Opportunities for Parents Empowerment) programme to enhance the practice of FCC within the South African context. Jardien-Baboo et al. (2016) also in South Africa explored the perceptions of nurses regarding patient-centred care in public hospitals. The findings revealed that the nurse participants perceived patient-centred as an awareness of the importance of patients' culture, family, respect and love and optimal communication in patient care. The barriers to patient-centred care according to this study include inadequate resources, increased administrative work, and unprofessionalism among staff. Factors that promote patient-centred care are a positive work environment, demonstration of good professional leadership, continuous education and collaborative teamwork within interdisciplinary team (Jardien-Baboo et al., 2016).

Beyond South Africa, there is limited knowledge on the FCC practice in other African contexts. At the time of conducting this literature search, only one related study was identified from Mozambique. Söderbäck and Christensson (2008), also acknowledging the gap in knowledge regarding family involvement in the care of

a child in hospital conducted a cross-sectorial study in Mozambique. Her findings revealed that Mozambican family caregivers in hospitals have low levels of education and are from a poor socioeconomic background. These factors contributed to difficulties in coping strategies family caregivers experienced in hospitals. Furthermore, the family caregivers had challenges with understanding issues related to hospital care, they were often provided with less information about care in the hospital. Despite these rather discouraging findings, Söderbäck and Christensson (2008) suggested that parents and family caregivers from the sub-Saharan African context have a desire to be involved in the care of the hospitalised child just as reported from the western countries. However, there is no such evidence reported from the Ghanaian context. Thus a gap in knowledge regarding FCC in Ghana and therefore the justification for this study.

## 2.6 The study purpose, research question and objectives

### *2.6.1 Purpose of the study*

The aim of this research is to explore perceptions regarding the concept of FCC held by health professionals and families caring for children involved in RTA in two tertiary hospitals in Ghana. It aims to understand the perceptions of parents and sick children about hospital care. Thus, the research objectives were posed to guide the conduct of the study, which ensured the realisation of the purpose of this study.

### *2.6.2 Research question*

The primary research question, which drives the study is:

How do parents and health professionals perceive Family Centred Care (FCC) for children hospitalised through Road Traffic Accidents (RTAs) in Ghana?

### *2.6.3 Study objectives*

The objectives of the study are to:

- Explore and describe the parent/family's perceptions of Family Centred Care (FCC) for children admitted to hospitals through Road Traffic Accidents (RTAs).
- Explore and describe nurses' perceptions of FCC for children hospitalised through RTA.
- Develop a conceptual model, which explains the perceptions of FCC in the Ghanaian context.

## **2.7 Conclusion**

The literature review accounted for in this chapter was based on the understanding that previous knowledge on a phenomenon understudy may serve the purpose of data source to be integrated into the research. Indeed the literature revealed that the FCC concept has several synonymous models, which were developed over many decades. The evolution of the concept was based on the emotional needs of sick children and their families at a particular point in time.



These needs were rooted in the approach to medical care practices, underpinned by institutional goals and targets. The documents reviewed revealed that studies on the evolution of the FCC concept were mostly from the western countries, especially from the UK, USA, and Canada. The search also established that there is limited information about the establishment of FCC as a care principle in Ghana. Therefore, the knowledge gained from the other contexts enabled identification of key concepts, their interpretations and relations to FCC. In conclusion, the chapter positioned that there is limited knowledge on FCC in the Ghanaian context. Hence, the guiding question and objectives for the study adopted an exploratory approach, which informed the choice of research methodology and method detailed in chapter three and four.

## 3 Chapter 3: Methodology

### 3.1 Introduction

This section presents methodological issues, informed by the philosophical beliefs underpinning this research. It details the ontological and epistemological orientation of the study. The chapter is divided into three sections. The first section outlines characteristics of qualitative paradigms followed by the philosophical positions of the study and lastly grounded theory, the methodology of choice for this study.

### 3.2 Placing the study within the interpretivism paradigm

In the world of social sciences there are two different traditions to conducting research; positivism or interpretivism, in other words, quantitative or qualitative approach, and recently both methods in one study labelled mixed methods, have become popular (Creswell, 2013). Deciding on the approach to a study depends on how the researcher views and conceptualises reality (Erlingsson and Brysiewicz, 2013). Both quantitative and qualitative paradigms have different epistemological and ontological assumptions underlying their practice (see Table 3:1). This section examines a wider description of the quantitative versus qualitative approach and justifies situating this study within the qualitative paradigm.

Table 3.1 Comparisons of research paradigms

Philosophical Underpinnings					
		Ontology	Epistemology	Positions	Methodology
Research Approach	Positivism	Assumptions that reality exists. There is a natural order of things. Research is aimed to reveal the only one truth of phenomenon investigated.	Investigator is independent. No degree of influence on investigation or on process. Emphasis on minimal level of bias. Findings are facts generalised and replicable.	Seeks explanations of human behaviour. Investigate cause and effect. Testing and proof hypothesis (etic-led inquiry).	Mostly experimental. Statistical quantification. Emphasis on discovery of social life. Use triangulation and several approaches to falsify hypothesis.
	Interpretivism	Reality is in multiple forms. Construct mentally in multiples through social and local experience in nature.	Findings created through interaction between investigator and participants.	Seeks understanding of human behaviour. Focused understanding of human action. Mainly explores participant meaning and experience (emic-focused inquiry)	Individual constructions are elicited and refined throughout the process. Distillation towards a consensus is formed and sophisticated.

Quantitative research is mainly oriented to testing theories using deductive approaches. Thus, beginning a study based on an existing theory or conceptual framework (Charmaz, 2006). The epistemology of quantitative studies based on the positivist ideology attempts to find the one 'truth' about a phenomenon under study (Lincoln and Guba, 1985). The objective fact is its ontological foundation. Based on these philosophical positions, quantitative techniques rely on numerical data collected commonly using questionnaires, structured interviews and observations (Eddy, 2016). In studies involving humans, the people in the study are referred to as respondents, who are recruited with different approached of randomised sampling. Generalisation of findings is a major goal of quantitative research and hence requires a large population of research respondents.

Statistical instruments are mainly used for data analysis and the analysis are aimed at establishing cause and effect, or testing theories (Eddy, 2016; Creswell, 2009).

Qualitative methodologies employ both inductive and deductive approaches to discover theories, explain concepts, and describe experiences or social behaviours in particular situations. Individual interpretation of social realities is the core of its epistemology. The ontological assumption of qualitative study is that the 'truth' about the study phenomenon must be viewed as constantly shifting product of perceptions. In other words, there is no single 'truth', in that multiple views exist on the same phenomenon. It therefore, places importance on understanding the behaviour and beliefs of people being studied (Creswell, 2013). In most cases, participants are sampled purposively. Data collection methods engage intense human involvement and reflexive processes of analysis (Braun, Virginia, Clarke, Victoria, 2013; Charmaz, 2014). The use of languages and interpretations made of them, explanations to behaviours and experiences and generation of theories are major goals of qualitative studies.

Despite the differences in the philosophical stance of quantitative and qualitative approaches, scholars have warned against making rigid distinctions between them (Creswell, 2014; Elder and Giele, 1998). This caution is based on the argument that each approach has a role to play in attempting to understand nature. Nevertheless, there is awareness about the paradigm conflicts that existed between quantitative and qualitative research scientist in the past

(Charmaz, 2014; Boeije, 2010). The growing trend in the scientific world in recent times suggest increasing acceptability of qualitative methods.

Traditionally developed and mostly used by anthropologists, qualitative research, however, offers and continues to provide many opportunities to nursing as a profession for the development of its body of knowledge and theories of care. A qualitative method offers a systematic approach with the goal to get a better understanding of complex human interactions (McCallin, 2003). Creswell appraised research designs in social sciences and reported that qualitative methods have gained recognition among social scientists, and have also drawn the attention of many young emerging scientists. However, he also cautioned beginning researchers to choose one approach from many qualitative methods to start their world of discovery (Creswell, 2007).

This research employs a qualitative approach base on the understanding that there is limited knowledge on the concept of FCC in Ghana and therefore requires a powerful tool that can assist in answering probing questions. Exploratory studies acknowledge the existence of multiple opinions, which produces a rich description and in-depth understanding of the phenomenon of focus. The previous chapter discussed how the FCC developed through social construction, which has generated different terminologies with varying understanding in contemporary practice. The novelty of this study in the Ghanaian context, therefore, merits a qualitative approach, which offers the opportunity to generate a full research process designed from conceptualisation of the research problems

through data generation to analysis and interpretation of findings. Furthermore, the quest to produce a comprehensive and holistic care of the RTA injured child in the hospital in Ghana informed the choice of a qualitative approach.

### 3.3 Philosophical underpinnings of the study

A fundamental requirement of a qualitative study is about the philosophical worldview that the researcher brings to the study. This should conform to a particular research design that relates to that worldview, and informs specific methods that translates into the approach of practice (Creswell, 2007).

#### 3.3.1 *The researcher's worldview assumptions*

Beliefs and worldview assumptions related to the care of a child with RTA injury in the hospital are presented;

- Children need care provided by the family
- Families by nature of being the primary carers will desire to give care to their children in hospital
- The perceptions of the concept of family centred care may not be congruent among families and health professionals

Based on the above beliefs, the concept “family care” and “family caring” were valued and placed at the centre of discussion within the ontological and epistemological domain of study.

### 3.3.2 *The ontology*

The ontological beliefs underpinning this study are my beliefs about the concept of care and caring and how it is view in the management of children in the hospital. The definition of care and caring as applied to this study are,

*“Care is a phenomenon related to assisting, supporting, or enabling experiences or behaviours toward or for others with evident or anticipated needs to ameliorate or improve a human condition or way of life” (Reynolds and Leininger, 1993 pg.18)*

*“Caring is actions and activities directed toward assisting, supporting, or enabling another individual, or group with evident or anticipated needs to ameliorate or improve a human condition or way of life, or to face death” (Reynolds and Leininger, 1993 pg.18)*

Care and caring is thus, viewed as the mode of being and an essential ingredient in human development and survival. Thus, care is part of the human experience of being in the world. As such, caring as a human trait applies to all facets of this study. In the nursing profession, many authors have investigated the concept of care and caring and especially its essence to nursing care (Åström, Norberg et al. 1995; Baldursdottir and Jonsdottir, 2002; Drenkard, 2008 and Edmundson, 2012).

The concept of care in nursing until today is regarded as a complex and arduous entity to explain (Edmundson, 2012). Nevertheless, caring is considered as the fundamental component of the nursing profession. It acts as a central and unifying domain of the nursing profession (Patistea and Siamanta, 1999).

According to Leininger (1985), the act of care enables the nurse to provide assistive, supportive or facilitative acts towards another individual (the sick child), or group (family) with evident or anticipated needs to better a human condition. The nurses' act of care to both the sick child and their families could enforce interpersonal and therapeutic relationship (Baldursdottir and Jonsdottir, 2002) of which both the nurse, patient and family benefits.

Caring as a universal phenomenon (Elder and Giele, 1998) infers that care is not neutral, but influenced by different factors beginning with the individual differences. Uniquely, individuals may have qualities, values and attributes which impact on the care they give. Tuck et al. (1998) expressed that human caring involves values, a will and commitment to care, knowledge, caring actions and consequences. Care in itself may also be in the form of physical, psychological, social and intellectual processes and experiences. The subjective nature of care implies that the recipients of care may also have their own perceived ideas about care.

Caring or caregiving viewed as being intentional and directional in the context of childcare requires more than one person to take place. This may be between the nurse and their patient, or in the case of the child patients, the nurse and the family. Patients and patients' relatives form part of the care process in hospital management of the sick. Similar thoughts view the concept care, as relational and require action. Thus, we have to interact with others as humans to maintain our well-being and they, in turn, have to interact with us. This is evidenced in the



day-to-day care efforts to the sick in hospitals. The nature of care in hospitals, although are aimed to achieve medical goals, the satisfaction of the players in care delivery is paramount. These form part of the consumer sensitivity, which guides responsibilities, and expectations of the components of care in the health institutions (McGee, 2005).

Expressions of care, processes and patterns may vary among cultures (Brown, 2011). Culture is a way of thinking and feeling by groups of people who share similar worldviews and that provides a particular way of being in the world (Nukunya, 2003; Assimeng, 1999; Napier et al., 2014). This brings about cultural diversity in what defines care, who should give care and in what context is care most needed and least relevant. It also highlights the point that care may be determined and influenced by the social settings we belong.

Indeed the African cultural context view caring and childcare in particular, as collective responsibilities shared among families and community members (Nukunya, 2003; World, 2010; Falola and Salm, 2002). This is better explained in the cultural tenets of "*Ubuntu*", a common expression of togetherness in the southern Africa culture. "*Ubuntu*" means that we are part of all humanity, and we are who we are through our interconnectedness with each other" (Marston, 2015). On this premise, the child involved in an RTA and subsequent hospitalisation does not only affect child and parents; it has a wider influence on families and communities. Marston (2015) asserts that the diagnosis of a child is viewed as a different world whereby the child assumes a new identity of a "patient" and that

world is unknown to the child's families and friends. The long duration of this new world of disease state and further changes in the physical appearance of the child may lead to episodes of stress and isolation for the child, families and entire family (Marston, 2015). This suggests that the caring for the sick child and the development of any new care intervention for the child within the African context must be rooted in the values and norms of togetherness.

The concept of caring in the context of child health care with the focus of togetherness is located within the principle of FCC. The FCC concept explained in the previous chapter is developed from a social construction. This was evident from the different perspectives and the evolutionary transformation the concept underwent before coming into being. Ideologies of social constructions emerged in social constructivism paradigm. The worldviews of social constructivism are therefore relevant to this study and inform the epistemological underpinnings which are discussed in the next section.

### *3.3.3 Epistemology*

Epistemology is the philosophical assumption which informs the nature of knowing, what can be known, and who can be the knower in a scientific sense. Various epistemological positions underpin different conduct of qualitative methodologies. Among them are the post-positivism, constructivism, transformative and pragmatism (Creswell, 2003). A careful review of research methods pointed to social constructivism as the best approach to this study. Social constructivism sometimes referred to as constructivist; lays emphasis on

interpretivism (see Tables 3.1 and 3.2). The constructivist holds the ideology of multiple realities and believes that reality is socially constructed. Individuals develop the meaning of the world they live and experience, hence seeking the understanding people make from their world is the main goal of the constructivist worldview. Researchers deal with complex factors and effects on the topic under study and project participants' subjective meaning of the real world. In the quest of knowledge construction, the constructivist is mindful of the process of interaction among individuals. The FCC concept is founded on a partnership between the health professionals and the family; therefore, a constructivist approach is well suited to the research question. The context of interaction and the role of the researcher all come to bear to shape interpretations. Social constructivism has its root in symbolic interactionism discussed below.

#### *3.3.4 Symbolic interactionism*

Symbolic interactionism refers to a theoretical perspective that illuminates the relationship between individuals and society (Stern and Schreiber, 2001), thus focuses on human experience (Licqurish and Seibold, 2011). It views the world of people actively going about their daily tasks, including how they accomplish those tasks. The focus on processes of interaction among people interest the researcher to explore. Symbolic interactionism offers theoretical perspectives that bring to the understanding of how humans actions are constructed and situated in the society. In other words, how do people construct, learn, accept and adapt to society; what meaning others give to socially constructed knowledge (Cruickshank, 2012). It recognises communication and the use of symbols and

objects to facilitate symbolic communication. Communication is a unique characteristic of humans, and the use of symbols to represent objects with commonly shared meaning is one essential means that enable effective communication (Stern and Schreiber, 2001).

There are several determinants of behaviours and interactions in the context of this study. Healthcare practices, in particular, are influenced by cultural beliefs, the level of education and socio-economic status. Health services are further subjected to a wider political influence. In the context of this study, the managerial structure and the institutional culture of a tertiary level hospital, the context of this study is one, which influences the human behaviour and interaction.

According to the symbolic interactionism, people in research are viewed as active participants rather than passive respondents (Charmaz, 2014). Humans formulate meanings of objects through the interchange of ideas with the self and others. It also assumes that our interpretations affect our actions; likewise, our actions inform our interpretations. Therefore, others influence actions and interpretations and subsequently we may change our meaning of situations when interrogated. Shared meanings among groups of people become the basis of commonality and cultural identification. Despite these thoughts of personal meanings and construct of issues, symbolic interactionism assumes that there are social structures in societies built by people. For example, the social norms in Ghana whereby health professionals are perceived to possess powers and control over the care of the sick in institutions may define the concept of FCC and

its operations in the Ghanaian context. Interaction is therefore, essential in the interpretation. Actions arise from interaction given the reconstructed past, present and future. Understanding shared symbols, and common meaning assigned them provided a basis for making judgements, predictions and planning (Stern and Schreiber, 2001; Birks and Mills, 2011).

Symbolic interaction sees the self as a social being rather than a psychological phenomenon. Constantly members of society affect the constructions of a person's life by what to look forward to and how they interact. Symbolic interactionism is a major theoretical perspective linked to grounded theory (Charmaz, 2014; Stern and Schreiber, 2001). Grounded theory investigates the interaction, behaviour and experiences as well as people's perceptions and thoughts about a complex phenomenon. Consequently, the need to delve into the literature of grounded theory as a type of qualitative approach was required and presented in the remaining sections of this chapter.

### 3.4 Grounded theory

Grounded Theory (GT) is one form of interpretive methodologies in social science including health care and very appealing to young qualitative research scientist (Harris, 2015). Developed by Glaser and Strauss in 1967, GT is popular mainly for its purpose of building theory from data (Glaser, 1978; Glaser and Strauss, 1967). As named, it is by no way a theory in itself but a method, which moves qualitative research findings beyond description to theory discovery (Birks and

Mills, 2011; Charmaz, 2006). Unique to this methodology are three basic canons; theory development from practical real world research, systematically gathering and analysing data simultaneously, and constant comparative analysis (Charmaz, 2014; Harris, 2015).

Grounded theory offers precise, yet flexible techniques and procedures to data gathering and analysis with the result being a substantive or formal theory (Bryant and Charmaz, 2007a). A theory presents an explanation for a particular phenomenon developed from empirical evidence in a real world setting. A substantive theory is one developed from research of a particular substantive area and might apply to that area or transferred to similar settings (McCann and Clark, 2003a). On the other hand, a formal theory is developed for a formal or conceptual area of sociological inquiry, hence more general (McCann and Clark, 2003a).

One other way GT differs from other qualitative methodologies is the approach to data collection and analysis. Unlike other methods, GT requires data gathering and conducting analysis concurrently. Thus, data is collected in bits, analysed before the collection of another piece of data. By this approach, it is expected that ideas emerging from the initial analysis direct subsequent data collection (what and where) for the purpose of developing a full understanding of emerging concepts. The process of data directing where to locate further information is termed theoretical sampling (Charmaz, 2006; Strauss and Corbin, 1990a).

Data analysis in GT takes a cyclical nature referred to as constant comparative analysis. Doing constant comparative analysis involves the process by which researchers identify codes and categories and their related properties. The four stages of constant comparative analysis established in the works of Glaser and Strauss and reported by McCann and Clark (2003a) are;

- Comparing incidents applicable to identified categories,
- Linking categories to their properties,
- Defining the theory and
- Communicating the theory discovered.

The process of constant comparative analysis occurs throughout the course of a grounded theory study until the final write-up is presented.

Memo writing is another distinct feature of GT (Birks and Mills, 2011; Charmaz, 2006; Bryant and Charmaz, 2007b). Memos are written records of the researcher's thought processes during the conduct of a grounded theory study. There is no specific formula to memo writing, as it varies in issues, coherence, intensity and theoretical content (Birks and Mills, 2011). Memo writing, in whatever form it may take, enhances the researcher's intellectual practice skills concerning the recording of vital information, which helps to transform and shape the research findings (Birks and Mills, 2011; Charmaz, 2014)

Acknowledged by many scientists, GT originally developed from social sciences research presents a credible platform for investigations into human conditions

(Licqurish and Seibold, 2011; Hunter et al., 2011; McCreaddie and Payne, 2010; Annells, 2007; González-Teruel and Abad-García, 2012). This has made GT appealing to the nursing profession and nurses have favoured its use in nursing theory developments (Harris, 2015; Holloway, Holloway and Wheeler, 2010). Furthermore, it offers clear guidelines over other interpretive approaches (Charmaz, 2006). For example, GT is clear on its appropriateness in areas where less is known (Glaser, 1978; Glaser and Strauss, 1967). Contemporary GT methods also outline specific guidelines on data analysis (Strauss and Corbin, 1998; Birks and Mills, 2011; Charmaz, 2014). The reflexive stance on application of methods and the influence of researchers' experience and background on topic researched are invited (Charmaz, 2014; Schreiber and Tomm-Bonde (2015).

The development of GT is credited to two sociologists Barney Glaser and Anselm Strauss in 1967 (Glaser, 1978; Birks and Mills, 2011; Bryant and Charmaz, 2007a). However, the two authors based on differences in their philosophical stance developed different opinions on the principles and methods for the GT techniques after some years (Charmaz, 2006). This further instigated wider debates on the GT approach between the founders and other scholars. The ongoing discussions have led to different versions of GT currently. Famous in the literature are three frequently referenced methods of GT, these include; the classic version often referred to as the original Glaserian GT, the Straussian GT, and the constructivist GT (Charmaz, 2006; Hunter et al., 2011a; McCann and Clark, 2003b; Birks, Chapman and Francis, 2006). The different dynamics of the three popular versions are outlined in Table 3:2.



**Table 3.2 The three types of grounded theory approaches**

	Classic	Straussian	Constructivist
Identifying the problem area	Emergent No initial literature review	Experience, pragmatism and literature	Sensitising concepts. Discipline-specific.
Conduct of research and developing theory	Laissez-faire theory generation	Paradigm model theory verification	Co-construction and reconstruction of data into theory
Relationship to participants	Independent.	Active	Co-construction.
Evaluating theory	Fit, work, relevance and modifiability	Validity Reliability Efficiency Sensitivity	Situating theory in time, place, culture and context Reflexivity rendering of the researcher's position
Coding	Open coding  Selective coding  Theoretical coding	Open coding  Axial coding  Selective coding	Line-by-line Conceptual coding and focused coding to synthesize large amounts of data.

Source: (Hunter et al., 2011a)

The classical version of GT originated from the seminal works of Glaser and Strauss in the 1960s (Glaser and Strauss, 1967). Often referred to as true GT by Glaser, classical GT places emphasis on theory development other than a conceptual description of the research method (Hunter et al., 2011a; Moore, 2010). Research aimed to investigate into areas that little is known about finds classical GT attractive and convincing (Glaser, 1978; Strauss and Corbin, 1990a). It espoused theory generation from a systematic approach to gathering raw data from scratch. An inductive approach to analysis applies throughout the research process. Needless of a hypothesis, the researcher is expected to remain open minded while sensitive to the emerging theory from data (Glaser, 1978). Glaser and Strauss outlined features distinct to evaluating the credibility of grounded theory study. The four features are; theory developed should fit the

area of targets, easy to understand during its' application, general for application in similar settings and condition. Lastly, a set of control measures which allow some levels of flexibility in the application (Elliott and Jordan, 2010; Elliott and Jordan, 2010; Glaser, 1978).

The previous chapter two demonstrated the limited knowledge on FCC practice in the Ghanaian context, and this suggests that the classical GT will be an option to consider in this study. Furthermore, the evaluative features outlined gave directions to areas that students will find helpful and critical to shaping their research findings. However, being a PhD study, an overview of detailed process and rationale for actions are required for ethical approval for conduct of the research, and a monitoring tool for evidence of progress with studies. A thorough read confirmed the challenges related to the lack of methods and guidelines to the conduct of research practice using the classical version approach (Hunter et al., 2011a). Harris (2015) cautioned that this also might pose a challenge to gaining ethical approval for a grounded theory research. The hidden methodological premise of the seminal works of the classic GT therefore, was a ground for which the other versions of GT were considered over the classical version. According to Birks and Mills (2011), a PhD research like this study is required to demonstrate a rigorous conduct of the proposed, studied phenomenon, which must stem from the philosophical underpinnings of the study to legitimise the methodological and the method of choice.

The Strauss and Corbin version of GT emerged based on four identified methodological stances, which in their views differ from the original classical GT. These include the orientation of the researcher about the data; the approach to data analysis; verification and validation; and the criteria for evaluation (Birks, Chapman and Francis, 2006). Strauss and Corbin (1998) identified the role of the researcher's background and its effects on the research process and product. They recognised researcher characteristics and experiences, as that which could influence objectivity and sensitivity of the research. In their views, activity is precipitated by a problematic situation, which in turn, stimulates the thought process to finding solutions to address the rising problematic activity. In this study, the researchers' knowledge and experience (section 1.2), which was influential in the conceptualisation of this researchable topic was outlined.

According to Strauss and Corbin (1990; 1998), the act of thinking, either spontaneous or planned may have temporal aspects. Furthermore, the product of thought processes during implementation often may be reassessed for its effectiveness. This pragmatic ideological stance believes that the world is made of processes, the future is built on the past, and hence the documentation of processes and memories of events is important. Based on these assumptions, Strauss and Corbin outlined sets of procedures of analysing a grounded theory data. These include three levels of coding: open, axial and selective coding. The extensive explanation they provided to these coding processes offer the practicability of the method to a novice researcher.

Strauss and Corbin proposed the idea of verifying and validating findings, which suggest the application of the deductive process in the data analysis (Strauss and Corbin, 1998). However, to many scholars, Strauss and Corbin did not clarify what they meant by the verification process (Walker and Myrick, 2006; Annells, 1997). The proposed evaluation of the inherent credibility of the entire research also focused on the adherence to processes and quality of the resultant theory developed. Largely, the Strauss and Corbin version of GT appealed to this study and its process such as a substantial review of the literature applied to this study. However, considering the African norms and ideologies, which lays emphasis on a shared participation in all enterprise, the constructivists GT was deemed fit and considered the most appropriate method for this study.

Contemporary constructivist approach by Charmaz (2006) is the third version of GT considered. The constructivist GT places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants (Charmaz, 2014; Charmaz, 2006). The constructionist GT applies assumptions of symbolic interactionism, though criticised as having a preconceived theoretical framework, which is contrary to the original inductive process of the classical grounded theory (Glaser 2007). Symbolic interactionism is a theoretical perspective, which assumes that people construct selves, society and reality through interaction. Holding this belief implies that meanings arise from actions, and in turn influence actions (Charmaz, 2006).

According to Charmaz (2014), the major versions of grounded theory constitute a collection of methods rather than an array of different methods. She argued that the area of differences should mostly be the fundamental assumptions underlying the various studies. Charmaz discussion of the GT methodology, therefore, could be viewed as a combination of both classical and Strauss and Corbin approach. She embraces Glaser's simplicity of the method (Glaser, 1978), however, differs in the idea of researcher and participants distancing from each other. Charmaz again leaned towards the Strauss and Corbin (1998) idea of the creation of knowledge from interactionism perspective. Thus, knowledge is a product of acting and interacting with self-reflective beings (Charmaz, 2014; Charmaz, 2006).

Another feature of constructivist GT as suggested by Charmaz is the emphasis on reflexivity approach to research. Reflexivity offers the researcher the opportunity to subjectively influence and declare research process and product (Charmaz, 2006). Being reflexive implies the researchers see themselves as part of the research process, reveal and commit to strategies. Concerns have been raised regarding reflexivity and remaining unbiased (Birks, Chapman and Francis, 2006). Charmaz maintained that the reflexive nature permitted enables the understanding of the cultural and social context a theory is generated (Charmaz, 2014).

Key features of this research conformed largely to Charmaz's contemporary constructivist approach to GT. The constructivist GT methodology is congruence

with African values and Ideologies (Ubuntu) (Schreiber and Tomm-Bonde, 2015). Schreiber and Tome-Bonde (2015) outlined the commonalities between the tenets of constructivist GT and the African values (see Table 3:3).

Although the term Ubuntu is not a common terminology in sub-Saharan Africa, the elements and characteristic of Ubuntu, as identified by Schreiber and Tome-Bonde (2015) are common beliefs and principles of the Ghanaian societies. As outlined in chapter one, Ghanaians are community dwelling people. They believe in communalism, collectivism and social justice. These beliefs affect all aspects of lives including knowledge generation.

**Table 3.3 comparing the fit between Ubuntu and constructivist grounded theory**

Ubuntu (An African value of togetherness)	Constructivist grounded theory
Interdependence/interconnectedness	Co-construction of meanings through member checking, data sharing, careful interviewing and questioning.
Mutuality - people are responsible to each other	Mutuality - researchers are responsible to participants.
Humans viewed relationally and dynamically	People are dynamic, always in interaction, creating their worlds of meaning
Reciprocity - relationships involve exchange	Reciprocity - relationships with participants involve exchange of ideas, perspectives, sometimes tangible or intangible gifts
Communalism/collectivism	CGT focus on collective experiences of the group ecological perspective explicated through conditional matrix
Solidarity	Not explicated in literature, but implicit in requirements to address power imbalances between researchers and participants
Ethic of social justice	Explicated by Charmaz (2005) and by MacDonald (2001). Implicit in requirements to address power imbalances between researchers and participants
Considers context	Considers context - concern for contextual features of the environment that influence and are influenced by the interaction in the identified social process/theory
Recognises inter-relationships of spirituality, environment, and material and immaterial realities	Seeks to uncover meanings and the actions that flow from those meanings; recognizing interconnectedness of people and their environments; allows for examination of spiritual and other non-material realities
Focus on inter-relationships	Focus on process, power and reflexivity
Reflexivity - people reflect on their actions and how they affect others	Reflexivity - researcher critically reflects on her influence on the research process and on participants.

Source: (Schreiber and Tomm-Bonde, 2015)

Charmaz's (2014) idea of constructivist GT shares in the following sets of procedures:

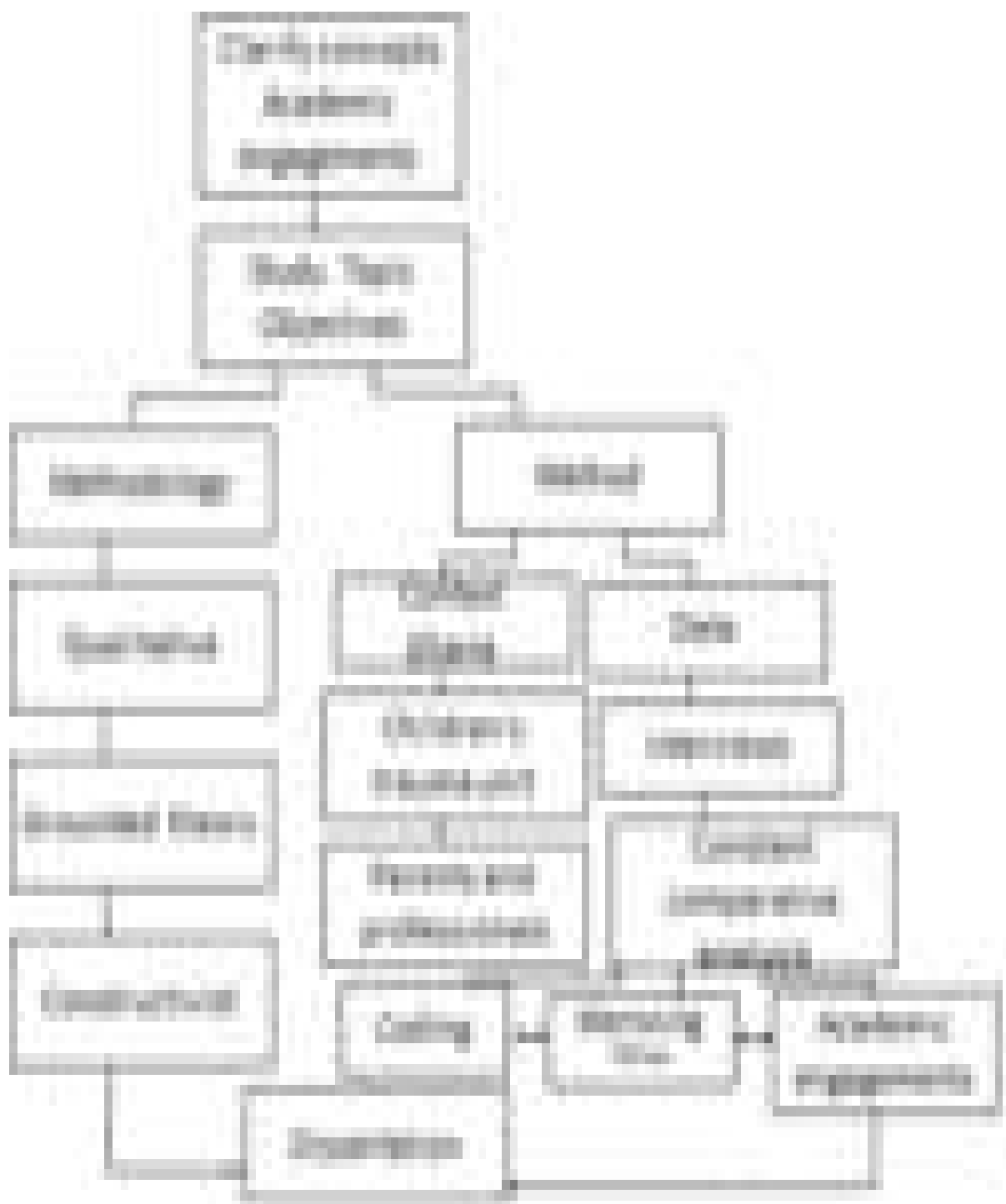
- Conduct data collection and analysis simultaneously in an iterative process
- Analyse actions and processes rather than themes and structure
- Use comparative methods
- Draw on both narrative and descriptive data to develop new conceptual categories

- Develop inductive abstract analytic categories through systematic data analysis.
- Emphasise theory construction rather than description or application of current theories
- Engage in theoretical sampling
- Search for variations in the studied categories or process
- Pursue developing a category rather than covering a specific empirical topic.

The methods in this research (see fig 3.1) draw on the Charmaz's (2014) set of procedures, and this is presented in the next chapter.



Figure 3.1 Linking methodology to method



### 3.5 Conclusion

A qualitative grounded theory approach to this research stemmed from the discussions in the previous chapter, which posited that there is limited knowledge of FCC in Ghana. However, an overview of the differences between qualitative and quantitative studies was necessary to demonstrate the understanding of the methods to social science studies. The chapter further outlined the basic tenets of grounded theory as one approach to qualitative methods. Grounded theory method, has seen some methodological alterations since its development, and this resulted in different versions of GT. The three leading versions were presented and the points of divergence discussed. The rationalisation of the choice of constructivist approach was given. The next chapter describes how grounded theory as a method was put into practice in this research.

## 4 Chapter 4: Method

### 4.1 Introduction

This chapter presents the set of procedures, techniques and thoughts that informed decisions for gathering and analysing data. Arriving at decisions on method took into consideration the philosophical beliefs regarding the ontology and epistemology of the study (see sections 3.3.2 and 3.3.3). Furthermore, the research objectives (section 2.6.3) and the process that attracts a high level of credibility to the study were factors considered. Based on the research objectives, which sought after perceptions of Family Centred Care (FCC) for children in Ghana, hospitalised through Road Traffic Accidents (RTA), the constructivist grounded theory was the method of choice.

The chapter therefore, presents various steps taken to achieve successful data gathering and analysis. It describes the study methods, which comprise of the study setting, participant sampling, data gathering and analysis procedures employed in the study. The ethical issues considered in the research, include applications to research ethics committees to gain approval for the study. The steps involved in protecting participants' interests are described.

## 4.2 The research setting

Grounded theory studies start with locating and accessing the field where one could gather rich data. Attention is paid to the phenomenon researched than a description of the setting of study (Charmaz, 2014). Nevertheless, Charmaz (2006) asserts that the credibility of a study increases partly, by the gathering of data from a range of contexts, perspectives and period (Birks and Mills, 2011). Two sites were chosen in Accra, the capital city of Ghana for this research. Accra is one city with significant representation of the major ethnic groupings in Ghana. Due to the growing economic activities within Accra, people from all over the country migrate in and out Accra on a regular basis. It is located at the south-eastern Ghana and shares boundaries with Ga district to the north, Tema district to the east and the Gulf of Guinea to the south. As the capital, Accra is multi-culturally inhabited, with six sub- districts. According to the 2010 national census, the total population of Accra is about 4 010 054 forming 16.3 percent of all the people of Ghana and as well, the second highest populated region after Ashanti region (Awusabo-Asare et al., 2013)

The condition researched, RTAs in Ghana is typically treated as a referral case due to the multiple injuries victims sustain. Accra, as the capital city of Ghana, has the highest number of tertiary level referral hospitals where trauma care services are available. The two hospitals purposively selected are both tertiary teaching hospitals. Furthermore, they both serve as national referral centres for Ghana and beyond. Patients from all over the country with major health

conditions as well as chronic diseases are often referred to either of these hospitals. Accidents and trauma units, not common in many hospitals in Ghana, however, are established in both hospitals. The trauma units in both sites provide services to children and adults. For reasons of confidentiality, a brief overview of the sites is given below.

The first research site is the first and largest teaching hospital in Ghana. Teaching hospitals in Ghana are independent executive agencies responsible for implementing the national policies outlined by the Ministry of Health (MOH). The Act of Government of Ghana, Act 525 of 1996, backs their functions and activities. The second research site is a military hospital, built in the year 1941 mainly for offering treatment to troops in the Second World War. This hospital also located in Accra, later opened to the Ghanaian public, and serves as one of the oldest tertiary hospitals specialised in trauma care in Ghana. Currently, it still operates as the property of the Ghana Armed forces. Significant to this research is the status of this hospital in relation to trauma management. It is the only officially designated hospital for trauma and emergency response in Ghana.

A child involved in an RTA is either sent directly or as a referred case to any of the two hospitals identified for this research. Given this, the study from the onset envisaged the availability of finding participants for the purpose of rich data required of a grounded theory research.

Teaching hospitals in Ghana and elsewhere in Africa are organised around specific functions, which direct policies and practice, of which some have influences on the findings and discussed chapter 8. For example, one of the primary functions of a teaching hospital is to have a direct link to a medical school or medical colleges, making most of the clinicians playing a dual role, thus teaching and consulting patients. These functions presuppose that the highest standard of healthcare policies and services are enforced. According to Akukwe (2008), a teaching hospital will lose its essence if it is not able to manage referrals and provide consistently high professional expertise, which is beyond what is typically available at other care facilities. This legitimises the high level of attraction of patients to these hospitals, which echoes the availability of participants from a diverse background for this study.

#### *4.2.1 Approval gained for the study*

The study gained approval from three ethics review committees. This involves the presentation of the study portfolio to all applicable Institutional Review Boards (IRB) for scrutiny. Adherence to key processes and correct application of essential sets of methods form part of the areas of concerns to most IRBs. At the initial stage of the research, a detailed proposal was written. This includes the background to the research, the research aims and objectives and proposed design of the research. Also, the study protocols including participant information sheet and the consent form were detailed. The timeline for the research, budget and source of funding were additional documents submitted.

The first approval was gained from the Faculty of Health and Life Sciences Human Research Ethics Committee, De Montfort University, England (see Appendix N). Subsequently, two ethics committees, Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana and 37 Military Hospital Institutional Review Board, reviewed and approved the conduct of the study (see Appendices N).

#### *4.2.2 Dealing with Gatekeepers*

The processes of gaining access to the two study sites were similar. The gatekeepers of the two hospitals were contacted separately to obtain approval to use their institutions for the research. Both hospitals required a submission of research portfolio, which are; a letter of introduction of the principal investigator (see Appendix K), evidence of ethics approval gained, study protocols including participant information sheet and the consent form (Appendices A-D).

I booked separate appointments with hospital administrators and directors of the nursing services to seek permission to access the children's units. The research portfolio was submitted for their information and any concerns regarding the research. On a later date, both hospitals, on separate occasions, invited me to answer questions raised about the study, as well as to clarify some doubts. Following their satisfactions with the details I provided, access to the children's units was granted through introductory letters (Appendix L) to the departmental heads and individual ward managers. One hospital gave a verbal approval with the explanation that the evidence of ethical approval from the hospitals' IRB was

enough and acceptable by their standard. Subsequently, a call to invite participants to the study was advertised on different notice boards in the units.

### 4.3 Sampling

Grounded theory in practice is not a linear process (Charmaz, 2014); the conduct of the data collection and analysis occurs systematically and concurrently (Strauss and Corbin, 1997). Constructivist grounded theory places emphasis on gathering rich data and suggests intensive interviewing as one common source of achieving this (Charmaz, 2014). It requires creativity, as well as flexibility in data generation and analysis. Founders of grounded theory direct researchers to adopt a high level of objectivity and sensitivity to the data collection and analysis (Glaser and Strauss, 1967). Strauss and Corbin (1998), doubting the possibility of achieving absolute objectivity while maintaining balance proposed open minded approach to field work instead. Alternatively, Charmaz (2006) suggests increasing the credibility of a study with detailed data captured from a range of participants, context, perspective and timeframes (Charmaz, 2006).

Different sampling techniques were employed to collect relevant information as the research advanced. The next section outlines the sampling strategy employed to recruit participants into the research. How intensive interviewing and data analysis done with reflexivity incorporated is further explained.



#### *4.3.1 The research participants*

The care of trauma patients involves a mix of interweaved activities and procedures performed by many different experts (Abdur-Rahman, van As and Rode, 2012). Likewise, the grounded theory method recognises good theories constructed from a variety of data sources and perspectives on the topic (Charmaz, 2014; Stern and Schreiber, 2001; Glaser, 1998). This understanding was applied in determining the research participants. Initially, nurses who give direct care to children admitted to hospital were included. Children in hospital with injuries from RTA and their family caregivers were also recruited. As data gathering and analysis progressed, there was the need for theoretical sampling. Theoretical sampling, therefore, suggested other sources to seek out for information to fill gaps during the data analysis.

Research studies must define the procedures used to identify the study population (Creswell, 2007). This research defined sets of inclusion criteria, which includes individuals who can provide the greatest insight into the research objectives. Thus, participants' professional qualification, exposure to the study phenomenon and experience are key to gathering rich information (Devers and Frankel, 2000). The inclusion criteria for the study were:

- Nurses who worked at least for a one year post qualification
- Must have worked at the children trauma and orthopaedic units a minimum of six months

Parents and family caregivers (both male and female) whose children on admission were involved in RTA:

- Had no communication impairment and were at least 18 years
- The child participant group included children between the ages of eight and 18 years on admission
- Had recovered from acute stage of illness

#### *4.3.2 Sampling strategy*

Purposive sampling is a basic tenet of qualitative research (Coyne, 1997). However, different types of purposive sampling exist with various rationales. Grounded theory mostly starts with selective sampling and advances to theoretical sampling. Both are examples of purposive sampling. Starting selective sampling, constructivist GT suggests a selection of research participants who have a first-hand experience that fit the research topic (Charmaz, 2014). Glaser (1978) refers to such as a calculated decision on research participant base on a preconceived knowledge guided by researcher's experience and familiarity with the studied environment. In the application of selective sampling, research participants are planned.

Theoretical sampling, a key feature of GT on the other hand, may be applied as data collection progresses in a research process. It is a sampling strategy determined by emerging concepts from the data analysis. Glaser (1978 pg.17) defines theoretical sampling as 'the process of data collection for generating

theory, whereby the analyst jointly collects, codes, and analyses data and decides which data to collect next and where to find them, to enable the theory to develop as it emerges. Charmaz (2014 pg.192) explains that theoretical sampling is “strategic, specific and systematic”. She agrees that this skill of sampling guides the researcher on where to go for information to elaborate and refine theoretical categories.

#### *4.3.3 Sampling for individual interviews*

At the research sites, the nurses’ station was the first place of contact. After an exchange of pleasantries, I explained the purpose of the visit to nursing staff on duty to identify potential participants. The inclusion criteria for all participant groups were announced on each visit. Nurses used their knowledge of patients and colleagues to direct me to potential participants. I interacted with potential participants to sample those who met the inclusion criteria. These included nurses, parents of RTA victims and children. Depending on the category of participants available at the time of the visit, a convenience sampling was conducted. For example, on some days of visits, a major ward round was ongoing and getting child’s family, or a child was challenging. On such days, nurses who were not involved in the ward rounds were sampled.

Sampling was effectively organised in some orderly way. It took the form of sampling two to three nurses, schedule interview dates, time and place planned and conducted. Interviews were scheduled within a period not too far apart to avoid losing sampled participants. The recording of field notes after each

interviews helped to formulate questions for each subsequent interview. This sampling method, which is slightly different from the norms of grounded theory, happened as nurses were often met in groups of two to four at the nurse's station. In addition to the public notice, information about the ongoing research was communicated to pockets of nurses met on each visit. Most nurses, upon learning about the study were instantly ready to participate in the study. Ignoring their readiness will informally send a signal of disrespect. Accepting their spontaneous readiness and conducting interviews with them risked most of the interviews becoming what Remenyi (2012) termed as impromptu interviews. An impromptu interview has its advantages and disadvantages. Though impromptu interviews can be insightful, they are often short and getting research information sheet read and consent signed becomes problematic.

It is important that researchers get to know the interest and concerns of individuals and be sensitive to them. During sampling, getting to know people and establishing rapport was essential to achieving responsiveness to participants' needs and cultural sensitivity. The strategies adopted included accommodating ward routines, being humble and respectful when interacting with participants, often establishing what I share in common with participants as well as adapting to hostilities.

In order to be consistent and orderly with the process, I sampled two to three parents separately on same days. Information about the study explained to them separately and interviews dates and time planned and conducted. In the case of

children, it was impossible to get more than a child at a particular period partly due to age related issues, the state of health or ineffective communication. An on-site sampling was employed at a stage and often characterised by settling for what was available.

#### *4.3.4 Theoretical Sampling*

By the grounded theory method, interview conducted at a time was transcribed, analysed before conducting the next interviews. Days were taken off to transcribe and analyse before moving on to the next participant group. The thoughts from previous analysis directed who was sampled next. As data gathering advanced, efforts were made towards doing more purposive and theoretical sampling than convenience. An example of such instances occurred when the code “Obeying and enforcing hospital rules” was generated. This code necessitated recruiting ward unit heads and nurse administrators to understand how rules are generated and implemented.

Theoretical sampling was possible as a result of the familiarity with study setting procedures and working relationship built with people over the time. At this stage, thoughts, ideas and concepts developed from data determined the path. Constant comparison of data, codes and categories, as well as constant revisit to the research objectives helped to minimise biases during data gathering and analysis. Another example was in the case of meeting financial challenges of childcare in hospital after involving in an RTA. There were different perceptions and conflicting thoughts on who bears the cost and how this affects the proper

processing of accident issues in the law court. Hence, theoretical sampling was applied to recruit experienced orthopaedic specialist who gave insights into the professionals' involved in the law enforcement in relation to the legal implication of a child's RTA case.

#### *4.3.5 Sample size*

A number of factors were considered in determining the sample size in this study. The exploratory nature of the study required a more widespread of topical areas to cover and to generate varied data. This idea was treated as a must for providing the variation needed for theory building (Rubin and Rubin, 2012; Seaman, 1987). It was observed that the broadness of areas explored initially produced the quantum of data from small sampled population. The determination of final sample size was based on data saturation, where no new dimension to the categories identified was forthcoming (Creswell, 1998; Creswell, 2013). Saturation in this study was achieved by exploring satisfactorily the dimensions of codes and categories identified to meet the research objectives and those that were major concerns of the research participants. The total population size was 43, comprising 19 parents and 24 health professionals.

#### **4.4 Ethical considerations of the study**

Prior to access to the research sites, hospitals protocols regarding the conduct of research with the selected hospitals were acknowledged and followed (see sections 4.2.1 and 4.2.2). The measures that ensure that participants were

protected from harm and their consent gained before participation were also considered and detailed in the following sections.

#### *4.4.1 Protection of participants*

It is recognised that research studies conducted with people are likely to affect participants' lives in some ways. Therefore, Denscombe, (2012) suggests that researchers conduct their studies in a manner that minimises adverse effect on study participants. The common rule, which applies to most researchers, therefore, is the provision of honest detailed information about the study procedures to participants, which largely minimises some potential harm to research participants (Wood and Kerr, 2011; Denscombe, 2010; Needham, 1999). Participants in this study indicated an understanding of the research process, the benefits and risk of participation and agreement to participate through an individually signed consent forms.

#### *4.4.2 Participants' information sheet and consent form*

Participants' information sheets (PIS) were developed for the different categories of research participants in this research (see Appendices A, B, C, D, E and F). These included the health professionals, parents and children participants groups. The information included covered the study topic, description of purpose and objectives of the study. Information about the principal investigator was presented. Contacts of the research supervisors were provided for the provision of further information to participants if required.

The language used for the development of the PIS for children under the age 16 was carefully considered. For the initial considerations of children participation in this study, the PIS was written for the different developmental age groups following the intellectual maturity level classified by Piaget theory of human development. Sentences were constructed with simple English words that the different age groups (8-10 years and 11-15 years) were able to read and understand. A pilot test was conducted on the PIS for children of ages 8 to 10 years and 11 to 15 years. Three children representing both age groups were recruited from a local church's Sunday school to participate in the pilot test on the PIS. In piloting the developed information sheet, the children were given sample forms to read and explain how they understood what they read. Suggestions for changes in some words were invited during the pilot testing. Consequently, some words in the PIS were adjusted according to the suggestions from the children. The children also reviewed the sections of the information sheet, which presented information in a pictorial form for easy understanding.

The researcher's postal address, email and phone contacts were provided to participants. This is to enable them to communicate their interest of participation in the study; however, this process did not work. All participants requested that the researcher to do a personal follow up on them to confirm their participation. Financial constraints and the possibility of forgetfulness were reasons participants cited for not wanting to post their consent to participation. The PIS also highlighted participants' ability to withdraw at any stage of the research without requiring any explanation from them if they so wished. There was no



financial or material gain to adult participants in the study and this was clearly stated. However, children who were initially recruited as potential participant were given a token of two exercise books, two pens and pencils although their involvement contributed limited information to the outcome of the research. Those who participated in the pilot test also received the same token. These were mentioned in the PIS for children.

After potential participants read and verbalised their understanding of the information about the study, those who are able to append their signatures signed a written consent form. Others thumb printed because they could not sign (see Appendices G and H). I counter signed as a witness and a copy of a signed consent form was given to each participant. Signed consent forms were only taken from participants who demonstrated that they have read and understood their involvement in the study. In some cases, verbal explanations were further added. The consent form gives the researcher evidence that participants have agreed to their inclusion in the study and that they have made informed decisions (Denscombe, 2010).

#### *4.4.3 Safety of the participants and researcher*

Researchers have a duty to think ahead and forecast any aspects of involvement with their research that could potentially cause harm either mentally or physically to self and participants (Wood and Kerr, 2011). No physical harm was anticipated as a result of the interview strategy. However, arrangements were made with participating hospitals for medical care in case of any unforeseen health related

event during the conduct of the study. There was no such eventuality during the conduct of this study.

Emotional stress and discomfort from interviews were also considered and measures to manage it were stated in the study information form. Participants were given the opportunity to choose their own dates, time and place of the conduct of the interviews to avoid unnecessary intrusion which could cause stress. Interview durations (between one hour to one hour twenty minutes) were not too long to pose undue stress. However, a nurse and two parents broke down in tears during their interview sections. In those instances, the interviews were stopped and continued at a later time. No participant required referral to emotional support services.

The safety of the researcher was also paramount to this study. The service of a professional driver was employed for commuting to the field and back. The drivers' presence within the vicinity of the fieldwork provided security to some extent. A family member made phone calls after every one hour to check on my safety on field days.

#### 4.5 Recruitment strategy

Recruitment of participants for this research took into consideration the research objectives, time and resources available for the entire process of the research. Exploration research in a large organisation requires representatives of different

actors with a direct link to the concept under study (Creswell, 2014; Wood and Kerr, 2011). In addition, the amount of time for completion of the entire research and presentation of the research report for assessment was the critical issues considered.

#### *4.5.1 Professional staff recruitment*

Nurses were directly approached on duty and given the study's information sheets (Appendix A). It was followed by verbal explanations of the study aims, risks and benefits, confidentiality, consents and free will to decline or withdrawal from the study. The nurses were given 24 to 48 hours to think through and decide whether to participate or not. Time was also made available for questioning and clarifying all concerned issues raised about the study. Almost all the nurses approached met the inclusion criteria, and they agreed to participate in the study at first time of meeting with them. Others scheduled dates for a revisit and their decisions communicated.

The nurses preferred interviews conducted during their working shift hours within the hospital environment. Appointments were booked, and nurse participants arranged offices within their departments for the interviews. In few cases, the nurses recommended other colleagues who were recruited. This happened as the snowballing recruitment strategy (Hammersley and Atkinson, 2007). Doctors were particularly recruited based on recommendations.

In other cases, the emerging concept informed specific recruitments. Thirty (30) nurses were approached, and twenty-one (21) were recruited and interviewed. The nine who did not participate in the study were those who either did not meet the inclusion criteria or were never seen again after the first contact. In all, only one potential nurse participant declined her participation in the study. Three surgeons were recruited based on their availability and recommendation by the departmental head of the medical units. The heads of the medical units were personally contacted, and the need to recruit surgeons into the study as theoretical samples was explained. All the three surgeons contacted gave consent for participation and were recruited. Twenty-four (24) health professionals participated in the study (see table 4.1).

**Table 4.1 Background information of professional participants**

Cod	Ethnicity	#Years of experience	Area of specialisation	Rank
SNP1	Ewe	6-10	Paediatrics	PNO
FNP1	Ga	3-5	GN	SSN
FNP2	Ewe	6-10	Physician asst.	SSN
FNP3	Akan	3-5	GN	NO
SNP2	Akan	6-10	GN	PNO
FNP4	Ga	3-5	GN	SSN
MNP1	Northern	6-10	Paediatrics	NO
FNP5	Akan	1-2	GN	NO
FNP6	Ga	3-5	GN	SNO
SNP3	Akan	31-35	Midwife	PNO
MNP2	Fante	11-15	GN	NO
FNP13	Ashanti	3-5	GN	SN
FNP7	Akwapim	6-10	GN	SSN
FNP8	Ga	3-5	GN	SN
SNP4	Ewe	31-35	Midwife	PNO
FNP9	Akan	3-5	GN	SNO
FNP10	Ga	11-15	Public health	NO
SNP6	Akan	31-35	GN	DDNS
FNP11	Fante	6-10	GN	SSN
SNP6	Ga	16-20	Midwife	PMO
FNP12	Akan	6-10	GN	SSN
OS1	Upper West	11-15	Orthopaedics /trauma	Specialist
OS2	Ewe	11-15	Orthopaedics/ Trauma	
OS3	Fante	11-15	Paediatric/ Orthopaedics	Consultant
<u>Keys</u> General Nursing (GN) Deputy Director of Nursing S(DDNS) Principal Nursing Officer (PNO) Senior Nursing Officer (SNO) Nursing Officer (NO) Senior Staff Nurse (SSN)			<u>Keys</u> Staff Nurse (SN) Female Nurse Participant(FNP) Male Nurse Participants (MNP) Orthopaedic Surgeon (OS) Senior Nurse Participant (SNP)	

#### 4.5.2 Patient family recruitments

Potential parents' participants were recruited with the assistance of the ward nurse in-charges and staff nurses. The nurses introduced the study to the parents in my presence and sometimes in my absence. Several appointments to meet

parents who expressed the interest of participation were arranged. Upon meeting participants, the details of the study were explained including participant roles, potential risks and benefits, consent and the ability to freely decline or withdraw from the study if so wished. Participants were given the information sheet of the study to read (Appendix B). A maximum of one-week was allowed for participants to think about their decisions of participation. In all cases, participants preferred a revisit to confirm their participation.

In all cases, parents approached were willing and ready to participate in the study and were recruited. The parents were encouraged to allow themselves for further thoughts and considerations. Mothers constitute the greater population of parent participants. In few instances, both mother and father were recruited and interviewed together. Only on two occasions, was a father alone recruited as a parent's participant. Two grandmothers and an auntie were also recruited as parents' participants. All recruiting and interviews occurred within the hospital premises, mainly at participant's preference and convenience.

In all 25 potential parental participants were contacted and nineteen (19) were recruited (see Table 4.2). The other six were discharged and some were never seen again. There was no incidence of refusal or withdrawal from the study.

Table 4.2: Background information of parents' participants

ID code	Ethnicity	Relationship to Patient	#children
MPP1	Fante	Mother	5
MPP2	Upper East	Mother	4
MPP3	Ewe	Mother	4
MPP4	Ewe	Mother	3
FPP1	Ewe	Father	3
MPP5	Ewe	Mother	4
MPP6	Northern	Mother	1
MPP7	Ga	Mother	3
FPP2	Guan	Father	3
FPP3	Pele (Guinea)	Father	5
MPP8	Ewe	Mother	2
GPP1	Ewe	Grandmother	6
MPP9	Akuapim	Mother	3
MPP10	Ga	Mother	5
MPP11	Dagaati	Mother	2
FPP4	Ga-Adangbe	Father	3
AP1	Grusi/ Upper East	Aunt	0
GPP2	Fante	Grandmother	8
FPP3	Ga	Mother	5
<u>Keys</u> Mother Participant (MP) Father Participant (FP)		<u>Keys</u> Grandparent Participant (GP) Auntie Participant (AP)	

#### 4.5.3 Child in the study

Children's involvement in this study was the most problematic process regarding their recruitment and the conduct of interviews. The challenge with the children involvement was mainly due to the acute ill health state of most of the children. Some potential child participants had problems communicating as a complication from the injuries they sustained. There were also few issues regarding the inability to provide privacy since most of them could not be moved out of bed and the ward environment was unfavourable for interviewing.

Initial attempts to recruit children followed similar procedure as the parent's recruitment, nurses assisted by introducing the study to families and a request of

involving their sick children in the study was made. In most cases, parents who participated in the study gave consent to their child's involvement. The details of the study including what involves in their participation, the potential risks and benefits, their assent and free will to stop me at any time they were not interested in continuing in the study were explained. All these were done in a simple language that children of different age groups could understand (Appendix C, D and E). However, the interviews with the children were unsuccessful due to my inability to provide privacy for a successful conduct of the interviews. Most of the children were reluctant to speak, probably due to the lack of privacy and the effects of injuries they sustained. The idea of including children in the study was aborted at the eighth recruitment attempts when it was obvious that the children admitted with RTA injuries and still in hospital could not say much to contribute to the outcome of the study.

#### 4.6 Data generation

Data for this study was generated mainly through interviews. The individual interviews, personally conducted, initially were unstructured. However, topic questions guided the initial unstructured interviews to avoid a possible digression from the research objectives. As data gathering advanced, the interviews took the form of semi-structured topic approach to allow emerging concepts to direct the focus of the conversations. As concepts and dimensions emerged, interviews were guided by probing questions to aid the full understandings and development



of concepts. The face-to-face individual interviews were digitally audio recorded and later transcribed.

#### *4.6.1 The interview*

Preparations for the interviews took the form of a pilot testing with a senior colleague. The rationale was to assess my interviewing skills and the recording equipment. A constructive feedback from the pre-test was useful in identifying the initial general and focused questions to ask interviewees (Charmaz, 2014; Glaser, 1998; Strauss and Corbin, 1997; Rubin and Rubin, 2012). It also helped increased my confidence for the real fieldwork.

Preparation of participant before the conduct of the interviews was deemed important in this study. The participants were assessed on their knowledge about interviews and their expectations regarding the time, depth of information and how interviews will be recorded. Participants were also assessed on their understanding of the content of the information sheet and all concerned questions clarified. There were checks to confirm that participants signed the consent forms before the start of the interviews. Participants were assured of privacy and confidentiality in order to gain their trust and confidence in the research and the principal researcher.

At the beginning of the interviews, normal conversations were initiated for the purposes of knowing more about the participants, what their concerns are and to establish rapport. In most cases, participants were asked to share their day-to-

day experience on the unit. Progressing on, a partially structured interview format was applied. In the focused manner, there were topical areas captured as bullets on paper to cover, but not necessarily follow in any particular manner. Thus, the use of aide-memoire evolved at different stages during the conduct of the interview (Birks and Mills, 2011). Such topics also varied depending on the category of participants (See appendix P). The sets of questions were used for different purposes during the data collection. In some cases, some were used to start a conversation, or to introduce new topics during the interview process, which mainly was conducted in a conversational manner. This concurs with Birks and Mills (2011) assertion that what the researcher ask participants, and how the questions are asked varies between and within the interviews.

The clinical interviews concentrated on the issues relating to managing children involved in RTA. Nurses were asked to share their experiences on caring for RTA victims who are children, the common presenting injuries of the children and professional interventions and management. To kick start conversations with parents, they were asked to share their views on the circumstances that led to the accidents and care available to the children. Children were asked about what happened that they were in hospital, however, attempted interviews with children was unsuccessful.

A relaxed and comfortable composure was adopted throughout the interviews. Sitting arrangements was informal and flexible during the interviewing sections. Participants were told that they could stop the interview at any point that they

wish to do so. The interactions with the participants took the form of informal conversations with respect to their views on the topics discussed. This enabled the interviewees to relax and share their experiences and perceptions. Earlier interviews lasted for one hour to one hour twenty minutes. Subsequently, some interviews lasted for only thirty minutes, especially in cases of theoretically sampled participants. There were many probing questions to get issues clearly stated. Example of phrases used as probing questions include, “how do you feel about that?”, “can you tell me more?” “And what happened after?” These probing questions enabled intensive and in-depth interviews with participants. In all, 43 individual interviews were conducted within one and half year span.

#### *4.6.2 Reflections on data gathering*

Charmaz (2014) criteria for ensuring data quality was adhered to. Thus, all possible background information about persons, processes and settings were collected to enable understanding of the context and reasons behind behaviours. Good rapport with participants was established through a directed conversation. Broad ranges of multiple participants were involved in capturing diverse perceptions on the FCC concept. Enough time was devoted to collecting data, as on the planned days of field visits, I was mostly available at the hospital for more than a day shift. Most often, eight hours to ten hours a day was spent at the hospital for participants who wanted further interactions and clarifications regarding the ongoing study. Data collection was not conducted in a one time-period, it occurred concurrently with data analysis over a period of a year and a half (February 2014 - May 2014, June 2014 – January 2015 and June 2015-

September 2015) to reveal changes in data gathered over time. Data gathering in bits and concurrent analysis allowed time for comparisons between data, codes and categories (Charmaz, 2014).

Charmaz (2014) suggested triangulation of participants and data source. As a novice researcher, I was enthusiastic at the initial stage of the study and was convinced to apply all the processes ascribed to the grounded theory method. I must say that the overwhelming excitement and the passion to carry out the study overshadowed my ability to think through the child involvement in this study. Therefore, I became frustrated when the data collection attempts with children were not yielding results. However, Charmaz (2014) again suggested that researchers must make the best use of how much data they have to explain the studied phenomenon.

It was also realised that in real world, it is a challenge to apply strictly, the set of steps proposed in research. For example, to ensure the concurrent data collection and analysis, grounded theorist proposed that data analysis follows soon after every data collected. Ensuring this process was a challenge due to participants' expectations and their sense of involvement in the research. This attitude stemmed from the cultural values of reciprocity and communal engagements in common task for a collective success. However, the concept of reflexivity ensured the introduction of some ingenious strategies to the data gathering process. For example, two to three interviews were conducted in a single fieldtrip due to the enthusiasms, availability and readiness of the

participants. Although this practice is unlike the grounded theory approach to data collection, the situation on the ground directs the way to go (Charmaz, 2014). This suggests that researchers must strive to be proactive to identify and forestall some distractive issues in developing studies. The ability of the researcher to remain focused is key.

#### 4.7 Data management

Interviews were recorded and initially saved on a digital voice recorder. These recordings were later transferred to group files on my personal computer. The interviews were conducted in English and Twi (the most commonly spoken local language in the study settings). Interviews conducted in Twi were translated into English and this was carefully done in order not to change the meanings participants want to bring across. All translated transcripts were crosschecked (member checking) with participants to ensure their views were correctly captured. The three lenses in member checking, the participants, myself (the researcher), and external readers (supervisory team) (Carlson, 2010) were the three entities whose constant reviews of the data and interpretations provided the basis for the trustworthiness of the data and study findings.

Member checking provided an opportunity for participants to approve the transcribed interviews granted (Carlson, 2010). Thus, the participants who could read and write, and were interested in member checking, were given the opportunity to review the transcribed data generated from their individual

interviews. Those who granted the interviews in local languages and desired to do member checking were taken through their translated interview transcripts. The participants checked for, and approved of their experiences and perceptions they shared during the interviews. They also checked for the phrases and terminologies they used were correctly translated.

The data were continually revisited, presented on several occasions to the supervisory team for discussions. The data was examined and cross-checked for accuracy of interpretation and coherent conveyance of the participant's narrative contributions (Carlson, 2010). Also, daily memos captured in the form of reflective journal during the fieldtrips were compared with the data. The memos contained thought process, major decisions, and personal reflections during my visit to the hospital. Verbatim quotes to support the research findings were all in English.

#### *4.7.1 Anonymity and confidentiality*

Denscombe (2012) cautioned that information collected during the conduct of studies must be treated as confidential, and this forms one of the ethical requirements under the research guidelines of the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana. In this study, anonymity was ensured by replacing participants' names with identification (ID) codes (see Tables 5.1 and 6.1). There were no names or descriptions of persons in the write-up. Information gathered from participants was kept in confidence between researcher, supervisors and the transcriber. The transcriber completed a confidentiality agreement form (see Appendix O). This confirmed her

commitment to maintaining the confidentiality of participants information shared in the interviews transcribed. The computers used for this study were password protected and storage files for the raw data were password protected. The hard copies of the transcribed data were kept under lock and key separate from the signed and thumb-printed consent forms so that the information about individual participants cannot be linked with any of the data. Hospitals and individual participants in the study were given the right of access to the anonymised findings of the study.

#### *4.7.2 Data storage*

Security measures were followed to protect information shared with participants. The participants' background information and signed consent forms were in my possession. They were put in separate files kept under lock and key in a cabinet in my house. Digital audio recording device with a recorded voice had no means of adding a password to block access by another user. Hence, on returning from the field, audio-recorded interviews were immediately transferred to files on my personal computer. Identification (ID) codes were assigned to the interviews during the transfer and no real names of participants were attached to interviews. Interviews files were saved on password protected computers and memory sticks. Caution was taken using the services of the professional transcriber. The original memory stick with password was passed on to the transcriber to work with. There was no need for the transcriber to transfer voice recorded interviews to her personal memory stick.

Both electronic and hard copies of data were securely stored in separate cabinets at DMU. Transcripts have no names labels on them. These documents shall be kept for a minimum of five years after completion of the study in case of any queries raised about the study in the future. After this period, all materials shall be destroyed.

#### 4.8 Data Analysis

Data analysis according to Charmaz (2014) is mainly about generating codes from data and developing codes into theory. In other words, data coding is synonymous to data analysis in grounded theory. Constructing codes involve assigning meanings and labels to fragments of data. Collectively, grounded theorists identified three levels of coding; initial/open coding, axial/focused and theoretical coding (Charmaz, 2014; Strauss and Corbin, 1990a). According to Charmaz (2014), a good-grounded theory study must develop through at least the first two levels of coding.

Open or initial coding involves closely studying data, word-by-word and line-by-line to identify actions and incidents and label them with phrases that describes what is going on in data. The technique of questioning data and comparing data to data is applied. Charmaz encourages the use of simple and short phrases that are of close resemblance to data, and the possible use of the participants own words (in vivo coding). An attitude of openness is required to ensure the



possibility of identifying theoretical concepts emerging directly from the data (Charmaz, 2014).

In accordance with the tenets of grounded theory method, data analysis begins right after the first interview using the constant comparative analysis approach. Constant comparative analysis involves inductive reasoning through the various data sets to identify emerging concepts and theories (Charmaz, 2014). Central to grounded theory analysis is the generation of codes. Coding involves the critical examining of the data, defining what it is happening in the data and labelling key emerging concepts with their meanings (Charmaz, 2014). The constant comparative continues by further comparing data with data, data with code, code with code, code with category, and category with concepts until concepts that are more abstract, and theories emerge. A concept is a descriptive word or label with closely related meanings embedded (Holloway, 2008).

A conscious effort to keep focused on the research problem area, purpose and objective is required to guide directions to discovering the relevant categories and dimensions of interest (Birks and Mills, 2011). This requirement stems from the assertions that everything in grounded theory is a potential concept (Glaser, 1978). Thus, the possibility of becoming distracted and losing focus of the substantive phenomenon under study is high. There is also high chances of being overwhelmed, resulting in a phenomenon known as analytical paralysis (Clarke, 2005).

Substantive areas of research such as the research questions and objectives were periodically revisited to maintain focus and to develop that important analytical depth and integration in regards to the emerging concept related to the phenomenon (FCC) under study (Birks and Mills, 2011). Specific questions were raised during the analysis to fully develop emerging themes. These strategies were applied to identify gaps early into data generation, which aided in further recruitments and the conduct of intensified interviews.

#### *4.8.1 Initial coding*

The initial coding, a line-by-line interaction with data (Charmaz, 2014) whereby the researcher moves swiftly to open up the data and as well observe for possible conceptual words and phrases (Birks and Mills, 2011) applied in this study. The audio recorded interviews were played several times along with attentive listening and reflections on important utterances and this helped to achieve immersion in the data. Transcripts were generated from interviews by listening and typing out word by word.

The initial coding involved a further reading of the transcribed interviews over a number of times. The transcripts read line-by-line were labelled with the meanings, they conveyed accordingly (see fig 4.1). In some cases, participants' words were used as label codes, a process referred to as in vivo coding. Examples of such in this study include "*Needed to fill in the gap*" and "*Sending them away*" This ensured that the codes stay as close to the data as possible (Charmaz, 2014). Different colour shades for writing as shown in fig 4.1 and

insertion of comments were used in the labelling and in capturing of memos alongside coding.

Figure 4.1 Example of initial line-by-coding of interview in word document



Questions were asked of the data alongside coding to identify issues, incidents, from whose point of view, actions and consequences. One challenge faced during the initial coding relates to the ability to adopt a “fresh eyes” approach, which enables the identification of new and unfamiliar concepts from the usual known routines. A constant practice of word-by-word, line-by-line and incidence-by-

incidence helped to develop codes. A table of all labels were put together for each interviews (see fig: 4.2), which generated several codes.

**Figure 4.2 Examples of listed open codes from initial interviews**

Codes from parents' interviews	Codes from nurses' interviews
<ul style="list-style-type: none"> <li>being hospitalised after</li> <li>other treatment is done</li> <li>accident</li> <li>first hospitalisation</li> <li>injury</li> <li>long treatment after</li> <li>accident</li> <li>Starting to prepare for</li> <li>the case of child accident</li> <li>Children left unsupervised</li> <li>Parents experiencing</li> <li>anger after a child</li> <li>injury/accident is difficult</li> <li>children are scared from</li> <li>negative experience</li> <li>Deadly facts</li> <li>Regrets</li> <li>Tension</li> <li>Challenges with</li> <li>accidents</li> <li>Impulsive behaviour</li> <li>effect</li> <li>The age is identified</li> <li>Experiences for positive</li> <li>children</li> <li>Parents perceive a trust in</li> <li>emergency situations</li> <li>Family responsibility for</li> <li>hospital stay</li> <li>Efforts to handle the fear</li> <li>of negligence</li> <li>Free of responsibility for</li> </ul>	<ul style="list-style-type: none"> <li>Treating nursing is really nursing</li> <li>All types of injuries handled together</li> <li>Physical and medical treated</li> <li>together</li> <li>Mothers are preferred choice to stay</li> <li>with children in hospital</li> <li>Handling trauma children is difficult</li> <li>Trauma gets severe in children</li> <li>Mother is responsible for child</li> <li>life</li> <li>Regular assessment needed in</li> <li>children</li> <li>Mothers perceived impact on the</li> <li>environment</li> <li>Mothers care is less care</li> <li>Nurses perceive mothers' fears</li> <li>Mother's relationship with the doctor</li> <li>is good</li> <li>Mothers experience multiple feelings</li> <li>Mothers watch up or down and we</li> <li>struggle for the children</li> <li>We pressure them psychologically</li> <li>for us that is trying to give</li> <li>psychological care</li> <li>Nurses identify areas for learning</li> <li>Nurses perceive to know all</li> <li>the paediatric nurse method at the</li> <li>unit</li> <li>Positive toward working with</li> <li>paediatric nurse</li> <li>The nurse explains role of family</li> <li>careless care</li> </ul>

#### *4.8.2 Focused coding*

The initial codes progressed intensively into the stage of focused coding. Focused coding involved identifying the substantial and frequently appearing earlier labels to sort through the larger data. This stage required decisions about which codes made analytic sense to categorise data convincingly and completely and in most cases met the research objectives (Strauss and Corbin, 1990a). As the initial codes are put together, re-grouped by the nature of some connectivity observed in them, categories and sub-categories begin to emerge. The rearrangement of codes and categories in ways that shows relationships in categories and sub-categories occurs with the mind-set that they are temporal and subject to change (Charmaz, 2014).

The focused coding in this study occurred with the use of the software package Nvivo to manage, organise and re-arrange the interviews data to its matching codes. The transcripts, initially prepared in word documents were directly imported into Nvivo software after manual coding of five interviews with several of the matching codes. Thus, the initial tabulated codes were uploaded into the NVivo software package as nodes. In the NVivo program, it was possible to open the interview transcripts alongside categories and subcategories for review purposes (see figure 4.3).

Also, within NVivo (see figure 4.3), it was possible to code data to more than one node, which enabled the constant comparisons process. Coding and categorising under both new and old nodes continued systematically until no new codes was

emerging (code saturation). All the interviewed transcripts were coded and this stage was the most difficult and boring aspect of the data analysis. In order to capture participants' perspectives and interpret them, the literature was avoided and coding and categorization were done solely by comparing data to data, data to codes and codes to categories. The focused coding stage ended officially with focus group discussions with some participants to have consensus on codes and categories or generate new ones.

Figure 4.3 Snapshot from NVivo transcript and emerging nodes



#### *4.8.3 The focus group discussions*

Charmaz (2014) discussed the idea of revisiting some previous participants in the initial data collection stage and also during theoretical sampling. In her view, these participants may provide vital analytical ideas similar to the role of key informants in ethnography study (Hammersley and Atkinson, 2007). Applying the concept of flexibility allowed in grounded theory research and researcher adding innovative ideas, a focus groups discussion method was introduced at a phase of this study. This phase served the purpose of data verifying and clarifying codes emerging from the analysis. It was to give opportunities to participants to discuss codes identified in the study and further contribute to codes where possible (Remenyi, 2012). It also served a debriefing purpose for participants.

Some authors view this process as member checking, which may also be possible on one-on-one basis with participants (Charmaz, 2006). However, this study adopted a group discussion on the basis that care to the injured child in hospitals occurs daily with the influence of many role players. The nurses, other health staff, parents, extended families and significant others together played various roles in the care for the children during the conduct of this study. These individuals were viewed as knowledgeable informants concerning the care of an RTA injured child in hospital. More so, children were admitted and housed in big rooms and care was given in community kind of settings. Different families interact and share ideas on regular basis during the caring process.

This study generated open discussions among parent and professional participants. Parents involved in the individual interviews formed groups of three to four members and invited me on several occasions for a further discussion relating to the research topic. Such participants were visited individually by way of member checking. They were reassured of their inputs in the final categories and dimensions. Hence, a focus group discussion planned and conducted as a follow-up was scheduled to provide insight on the emerging categories with participants (Birks and Mills, 2011; Melendez, 2008; Krueger and Casey, 2000).

#### *4.8.4 The process*

The parents and nurses who participated in the individual interviews were contacted by phone to invite them to the group discussion. Tentative dates and time were proposed for their considerations. Some participants were persuaded to accept the suitable dates and times selected by the majority. Three focus group discussions were conducted. The first discussion was conducted with the parents group. The meeting was held at a neutral place, in a conference room of one of the public universities in Ghana. All the nineteen participants were contacted through phone calls. Twelve of the calls were received and eight of them confirmed to participate in the discussion. In the event, all twelve of the invited mothers, attended the focus group.

The second and third group discussions were conducted one week apart. These were with nurses at the two hospitals of the study sites. Attempts to recruit nurses by phone call were unsuccessful. Hence, frequent visits were made to the



hospitals and the nurses who participated in the individual interviews were contacted and invited. Almost all participants suggested conduct of the discussions occurred at their hospital environments. This resulted in the two discussion groups of nurses at the separate hospitals. One hospital had seven participants attending of which three were nurse managers. The second nursing group registered eleven attendants and had three nurse managers, four new participating nurses joined in to observe the discussions.

A colleague member of faculty was appointed the moderator for the three focus group discussions. Discussions were recorded by means of note taking. Participants were welcomed to the group discussions and with their help; the ground rules for the discussions were generated. The purpose of the meeting was explained right from the onset. With their permission, a PowerPoint presentation on the analysis process and the category generated were presented. The presentations for each group lasted for twenty minutes. These generated further discussions among participants. Group discussions lasted one hour thirty minutes each. All codes and subcategories were accepted. Participants confirmed and contributed to the descriptions of some codes. For example, nurses confirmed the code "*sending them away*" however they strongly justified their actions that the anxiety responses of most parents are more distractive than the complexities of the injuries children sustained. Parents also confirmed that watching their child from a distance without much information increases their emotional reactions. Hence, according to parents, managing emotions required prayers and having faith in God.

#### 4.8.5 Theoretical coding and model development

The final stage of the analysis involved theoretical coding. A clear theoretical model (see fig 6.2) only emerged late towards the end of the analysis process when all categories and subcategory were put together. The process of analysis progressed with the subcategories. Adopting the flexibility allowed in grounded theory, emerging thoughts, codes, subcategories and categories were continuously reviewed, refined and clarified (see Table 4:3).

**Table 4.3 Examples of preliminary categories**

Parents interviews		Professionals interviews	
Subcategories	Codes	Subcategories	Codes
Emotional reactions	Blame & Guilt Anxiety & worry Sadness, fear & hope Expressing faith in God	Parental involvement	"It is about a nurse and family patient relationship" Allaying children's fear "A pair of hand" Mothers as the preferred carer Working hand-in hand
Parental care roles	"Comforting my child" "When I'm needed" "Filling the gap" Physical care	Communication	Informing and explaining Instructions Education
Care burden	Structured visit schedule "Being sent out" Unpalatable hospital food Financing care cost Staff attitude	Setting boundaries	Uncooperative parents "Sending them away" Averting Uncooperative parents Enforcing traditions
Coping approaches	Getting to know someone Receiving staff help Being appreciative Expressing faith in God Being appreciative	Support	Openness towards parental involvement Staff calls to aid parental involvement

This process allowed for some abstract thoughts and labels across the two data sets. Theoretical categories, parental presence and family involvement were

developed. For example, ***parental presence*** emerged based on the most frequent representative of the family in hospital and participants perceptions of who the child's family is in hospital. The parent participants were in hospital for different purposes, had individual unique experiences, and perceived childcare differently. Thus, properties of the core category ***parental presence*** refined as *managing emotions, parental care roles, negotiating the system and challenges encountered*.

Moving forward with similar processes of continuous reviews and across the professionals' data sets, the category, ***family involvement*** was developed. The preliminary subcategories from the professionals' data were refined to *parental involvement, communication, setting boundaries and support to parental involvement*.

## 4.9 Conclusion

This chapter explained the method and conduct of the study and analysis. The tenets of the chosen methodology, constructivist grounded theory guided the approach to data gathering and concurrent analysis. The next chapters, five and six explain the findings from the parents and professionals data sets respectively. Chapter seven discusses the findings within the literature context.

## 5 Chapter 5: Findings: Parental presence

### 5.1 Introduction

This chapter and the next that follows present the findings of the research. The findings were generated from the data analysis process as described in section 4.8. Several emerging codes together constructed the sub-categories. Two core categories, parental presence, and family involvement emerged from the parents and professionals data respectively. This chapter presents the details of parental presence, the core category that emerged from the parents' data. Direct verbatim quotes from interviews are used to support the codes and sub-categories accordingly.

The chapter is organised into three sections. The first section presents the demographic characteristics of parent participants followed by the presentation of the core category parental presence, and its four subcategories. The third section summarises the findings from the parents' interviews.

### 5.2 Demographic characteristics of parent participants

The findings presented in this chapter emerged from data gathered in nineteen (19) interviews with family members of sick children as presented in table 5.1.

Table 5.1 Parent participants involved in individual interviews

Category	Number	Identification (ID) code
Mothers	12	MPP1-MPP12 (Mother Parent Participant)
Aunt	1	AP1(Auntie Participant)
Fathers	4	FPP1-FPP4 (father parent participant)
Grandmothers	2	GPP1-GPP2 (grandparent participant)

Table 6.1 shows that the parent participants involved twelve mothers (12), fours (4) fathers, two (2) grandmothers and one aunt (1). Identity codes used in this research to ensure anonymity of the categories of participants were; Mother Parent Participant (MPP), Father Parent Participant (FPP), Aunt (AP) and Grandmother Participants (GPP).

Family member participants were mostly parents, two grandmothers and one auntie of a child (Table 6:1). In view of this, all family member participants (be they biological or surrogate parent) shall be referred to as parent participant. The majority of parents had more than two children with one parent recording eight children. The ethnic background of participants varied in the sense that almost all the major ethnic groups in Ghana (see section 1.4) were represented (see Tables 4.1 and 4.2.). The highest educational background of parents was high school leavers' certification. None of the parents were in formal employment. The majority were traders, and the rest were skilled vocational self-employed workers. Out of the nineteen participants, only two were Muslims, with one being a traditionalist; the rest were Christians.

### 5.3 Parental Presence

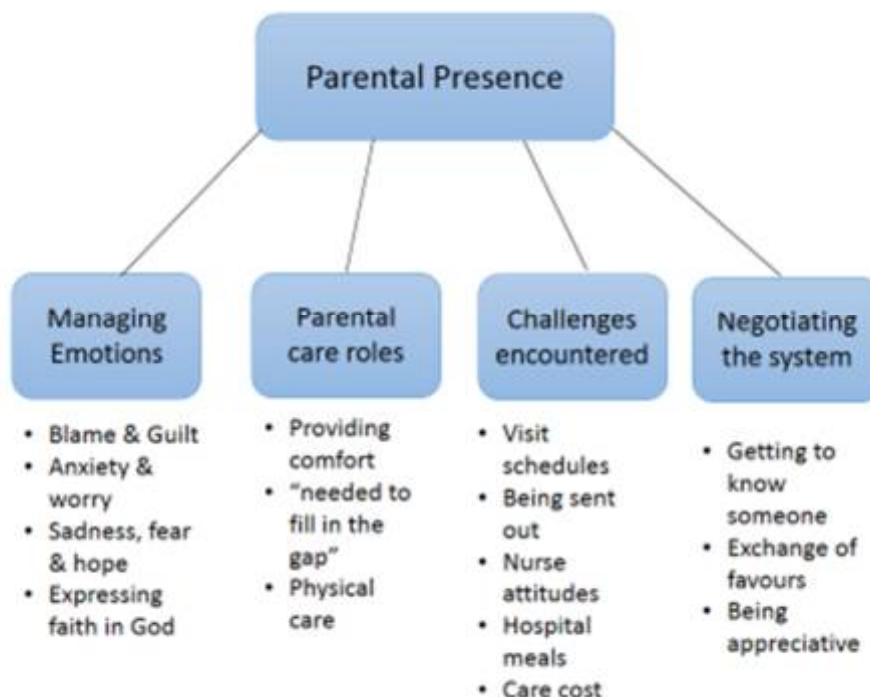
This research sought to explore perceptions of FCC for children hospitalised through RTA. The initial opening question to parent participants was “what is happening to your child here in the hospital?” The participants’ responses began with a description of the circumstances that led to their child’s involvement in RTAs and eventual hospitalisation. Essentially, participants described RTAs as traumatic, unexpected emergencies, which derailed regular family life, accompanied by periods of uncertainty and apprehension. Parents’ responses to the initial question thus set the tone for subsequent discussions and further probing.

Several codes emerged from probes and analysis of data. A range of similar codes grouped according to their common ideas, characteristics, and dimensions generated four sub-categories from the parents’ interviews. These are *managing emotions*, *parental care roles*, *negotiating the system and challenges encountered*. All four sub-categories together generated one core category, ***parental presence***.

Despite the label ***parental presence***, supporting quotes are mainly from mothers’ interviews since they formed the majority of parents and family caregivers in the hospital. However, there was an evidence of father involvement in care, and a few scattered supporting quotes from fathers are evident in this presentation. The first and early emerging sub-category under parental presence was *managing*

*emotions*. Several emotional reactions were reported following the events of child's involvement in an RTA. Invariably, parent's main concerns centred on the fear of being accused of parental carelessness regarding the child care, anxiety from uncertainties surrounding healthcare outcomes, and the possibility of the children losing their lives following the severe injuries they sustained. The act of parenting and the desire to continue parenting children in the hospital also emerged from interviews with parent participants. These generated the sub-category *parental care roles*. Whether parenting in hospitals was favoured or not, the parents *encountered challenges*. The challenges in parents' participation were grouped to form one subcategory. Parents described various ways they *negotiated the health care system* throughout their stay in the hospital to manage with administrative, logistic and interpersonal relationship challenges. The category **parental presence** and its sub-categories are presented in figure 5.1.

Figure 5.1 Parent experiences of caring for the children in hospital



## 5.4 Managing emotions

Managing emotions was the first emerging subcategory, which came to my notice from the interviews with parents. This subcategory describes parents' apprehensions and anxieties about their children's involvement in the RTA. According to the parents' accounts, the severity of injuries the children sustained significantly influenced their feelings and reactions. In addition, parents' emotional reactions were influenced by casual comments made by others. Public expressions of sympathy, as well as comments and remarks by onlookers and passers-by, tend to drive home the stark reality of the misfortune. Additionally, parents' experiences of hospital stay and their participation in care for the injured child contributed to their emotions. By way of dealing with their emotions, parents



utilised coping approaches such as expressing faith in God to deal with their fears and increase in hopes. The subcategory of managing emotions was presented under four codes. These are *blame and guilt*, *anxiety and worry*, *sadness*, *fear and hope* and finally, *expressing faith in God*

#### 5.4.1 *Blame and guilt*

One of the initial emotions following RTA was self-blame and guilt for children's accident. Typical expressions of such emotions were,

*"...letting down my guard a little..." MPP3*

*"I felt guilty and blamed myself" MPP4*

*"I blamed myself because I feel I should have been smarter..."*

**MPP1**

The expression of "letting down my guard" according to mother MPP3 was simply to say that she was not careful enough to prevent her child's involvement in the accident. She further explained that very often the child was supervised to cross the road. However, on the day of the accident, the family forgot to oversee the child to cross the street.

*"Often when I send him, I make sure that he crosses the road safely before I leave, but that day I really forgot totally. So, in fact, something nearly happened to me...I felt guilty" MPP3*

Supervision of children and parenting were perceived as generally complex roles for which parents expressed sentiments, which indicated that they were not on top of issues. These perceptions were common factors that placed parents in a state of self-blame. For example, it was identified that even when families were together at home, in many cases, the adults could not give an accurate account of the whereabouts of children in the family. It is mostly in such forgetful moments that children found their way to the street alone and the subsequent involvement in reported RTAs.

*“Ok, what actually happened was that I was sitting at home and my child was also playing on the compound. We live close to a busy road. After some few hours, I was informed that a car had hit my child. I was not sure, when exactly he went out... so can't we allow the children to play? Must I tie this boy down? Hmmm...When I was told I just rushed to the scene and there were people around who were asking 'where is his mother...and she has left this little boy to be all alone?'...I felt guilty upon hearing such comments...” MPP4*

It was obvious that some of the guilt feelings were compounded by casual comments made by others (Example as MPP3 reported under section 5.4.1) to make the guilt even more acute. In a similar regrettable statement, another parent expressed her surprise and guilt at the news of her child's involvement in a road accident.

*“I was in the house with him, I was even surprised at the time he got up and managed to go there...I blamed myself because I feel I should have been smarter...” MPP1*

Parents expressed the desire to give children the opportunity to play and to explore their environments. Consequently, most of the RTA cases in this study

were children who went to play within their neighbourhoods without adult supervision. One parent narrated a scenario where her child and another little child left home by themselves to play.

*"I was at home washing when another boy went out with her to play. I assumed they were in front of the house since that was their regular playground. However, in less than an hour, someone came to tell me that she has been knocked down by a vehicle..." MPP5*

One mother blamed her child's school for contributing to the child's involvement in the motor accident. This mother expressed her anger throughout the interview. The anger was due to the loss of her child's leg as a result of her accident. The child is a young little girl of nine years, got one of her legs amputated at knee level, an outcome of the severity of her injuries.

*"Talking about how I feel...it is very painful and I do not know, but there is nothing that can be done to compensate me. I put all the blame on the school. I always send my children to school and pick them. However, that day, I do not know why the school closed the children early to go home because it was about to rain. Our house is not too far from the school, so the children were crossing over to come home on their own. Unfortunately, a trotro (public commercial minibus) knocked her down. I am filled with anger..." MPP7*

Few other parents expressed anger at the drivers and other motorists. The common perception was that drivers and especially commercial drivers were impatient on the road.

*"According to an eyewitness, the driver was driving at top speed. My child and one other boy were crossing the road and this oncoming vehicle driving with speed knocked him and his leg went under the car but the other child was smart so he escaped" MPP4*

*“Drivers drive carelessly. They are never mindful of children crossing the road. I felt angry initially because this driver hit my child at the zebra crossing...” MPP5*

Despite the carelessness of drivers, which often went unnoticed, the source of the guilt for most parents arose from the perception that they ought to know the whereabouts of their children at all times.

*“...it is advisable that parents get to know the whereabouts of their children” MPP5*

*“We the parents must take good care of our children. That is what needs to be done. What I have realised these days is that everybody should be able to camp his child because when you leave them a driver might just knock and kill your child and all your efforts in bringing up the child will be in vain” FPP1.*

A few parents externalised the cause of the accident to supernatural influences because they had premonitions before its occurrence. Here, the participant had an ominous belief that a powerful external invisible force may have been at work even before the incident. Moreover, the “force” in question may have triggered the misfortune of the child’s accident. Such spiritual beliefs are extreme within Ghanaian society and culture, even among the educated and enlightened.

*“That particular Friday I was not feeling okay at all, I couldn’t tell what is coming up...I felt that something bad will happen and lo and behold; my child had an accident” FPP3*

Implicit in the above statement is the acknowledgement that there was likely a supernatural dimension to the accident. Just as this served as an opportunity for some parents to offload the blame on higher powers, it equally gave cause for parents to be worried and anxious as they questioned the depth of their faith and

spiritual strength. Even to some extent, some parents were doubtful if prayer works at all.

*“For me, I think it is spiritual” MPP12*

*“There are some instances you can tell it is spiritual. Before the accident occurred, they went to church, and the pastor called all the three children and told them that something would happen to one of them. So the congregation prayed. So when the thing happened, I did not want to blame anyone because I thought it was spiritual” MPP4.*

*“...we pray all the time. Sometimes you can feel it in your spirit that something bad is about to happen. In fact that day, I was not feeling right so I asked her not to go to school...I was praying even on my way to the market...but see us here...I don't know if I didn't pray well enough to have prevented this calamity” MPP12*

Mixed emotions such as self-blame, ascribing the blame to others, guilt and anger were observed in the statements of parents. Parents were also superstitious as some expressed perceptions that there were hidden forces behind their children's accidents. The above views from parents that they were inadequate to provide both physical and spiritual protection for their children compounded their self-blame and guilt feelings.

#### *5.4.2 Anxiety and worry*

Anxiety and worry were other emotions, which resulted from the fear of the unknown; and a contributing factor, which motivated parents to stay in the hospital with their sick children. Parents were worried and anxious about unknown variables surrounding care of their injured child, the outcome of medical treatment options and even the possibility of losing the child to death.

*“...I was worried because I did not know if the child will get well or if he will die, I cannot really describe it but the anxiety and worry was there and she (a nurse) made me feel that if the child will survive or not will depend on God” MPP1*

The above was a sentiment of a mother who was worried because the outcome of the child's treatment was unclear. The nurse's statement seemed to lead to greater anxiety than was already the case, as parents perceived that during those initial phases of care, the nurse-parent interaction was on minimal occasions. None of the parents had any experience of hospitalisation with children involved in physical trauma. Hence, the new experience and the challenges of learning to care for children with severe trauma made some parents anxious and worried.

*“Because I had not witnessed something like that before I could not control myself. I was very anxious. Yes and many thoughts were running through my mind. Thoughts like what will happen to the child. Will he walk again? And will he be amputated? The thoughts were many...I was really worried” MPP3*

In the Ghanaian context, the expression “*not able to control oneself*” as stated in the above quote have several implicit meanings. It is popularly used to mean actions and reactions that may be regarded as an extreme expression of anxiety. In this context, the parent used the expression to denote her reaction to the sudden news of her child's involvement in RTA. It was a way to communicate the gravity of her anxieties. Many of such expressions of anxieties and worries were reported in the study. Examples were “*near death*,” “*throwing self on the ground*,” “*running around*,” “*and weeping all the way to the hospital*” and “*incontinence and a sudden overwhelming urge to urinate*”.

*"Eiiii! I almost died; I fell to the ground because I could not imagine how that could happen...because it is early in the morning...what if they were dead? Who would listen to my story? Where can I get help...in fact I was anxious" MPP1*

*"I wept all the way from home to the main road... so together with a friend and my sister, we left for the hospital...when I saw my child, I thought she was dead..." MPP7*

*"Immediately I heard the news I urinated on myself three times... we started roaming every hospital in the whole neighbourhood looking for my child ... we had turned into mad people..." MPP8*

*"The first time I saw her I fainted and because I am also an asthmatic, I had an attack...it's a big problem and I worry a lot about it" MPP10*

According to mother MPP8, upon the report of her child's involvement in the road accident, a search of hospitals to locate her injured child was embarked on, a process she described as turning them "mad". Such reports were common in this research, which indicated that parents' anxieties and worries also stemmed from the searching process to locate the injured child. As parents were often not at the accident scene, conveyers of accident news to parents often had no idea of which hospital children were taken for treatment. Parents reported the effect of worries on their functioning abilities. They were unable to sleep and others were restless.

*"...I cannot sleep at night...because I am worried" MPP3*

*"I was worried. I rushed here the next morning together with my brother just to come and meet this situation. I must say that it was not easy at all; because I was worried, I was very restless" MPP6*

Perhaps some of the above descriptions and choices of the words could be regarded as embellished and exaggerated account of events; however, parents reiterated that these experiences were true reflections of how serious the child's

accident affected their lives. Furthermore, responses from onlookers appeared to contribute to the parent's levels of anxieties. One mother reported that onlookers and strangers in the hospital chastised her for being the cause of her child's accident.

*"Oh when we got to the hospital, some people were insulting me, I do not even know them, they were saying, where is the mother of the child? And she had neglected the child and he was walking about carelessly. I did not mind them...it is worrying for people to think that I was careless...very worrying" MPP3*

Such similar comments from staffs even made parents' anxiety levels acute as a different mother reported that upon arrival at the hospital, the nurse initially insulted her.

*"...I was very hurt; that a car had hit my child and you (the nurse) are adding insult to my pain, it really hurts...very worrying" MPP1*

It seems that at the early stages of the reports of accident events and the initial stages of hospitalisation, parents were at the heights of their anxieties and any negative comment increases their guilt, anxiety and worries.

#### *5.4.3 Sadness, fear and hope*

Parents in this study expressed sadness about their children's poor state of health in hospital. They felt sad when the news about the accidents was broken to them. Some said they wept, cried uncontrollably and shouted hysterically for help.

*"...I wept all the way from home to the main road where the accident occurred. In fact, I cried for help...today I see my son here in a bandage and I feel so sad" MPP11*



*"I cried all the way from the house until I got to the hospital...When I saw my child, I thought she was dead but by the grace of God, I heard her cry...she was not dead...but the condition she is now...hmmm, it's sad" MPP8*

*"I went into a state of shock because that was not the state I had left my child in the morning and seeing her covered in blood frightened me and I became very sad" MPP2*

The unthinkable prospect of death was a common feeling and expressions, which instilled fear among parents. Some parents recounted fear of realising that their children could potentially die from their injuries. They remained sad even when *they had every evidence and reassurance that their children were alive, and receiving treatment.*

*"I became very sad, I did not even know she would become strong like this" MPP9*

*"I was very sad but I had hope that once she has been brought here, she will be fine" FPP3*

Parents reported that they were very sad at their children's helpless and critical conditions. Although they were sad, they also expressed hope and faith. A few parent actually expressed trust and hope in the hospital system.

*"I believe once I got here (Hospital), there is nothing more to fear. I always believed that my child will be well" MPP5*

*"They do well here the doctors and nurses are good. Especially the young nurses (student nurses), they are always around to talk to the children, I am very hopeful that they are doing the best for my son" FPP3*

Focusing beyond the current conditions of children, parents also expressed concerns about their children's feelings and the implications of the accident on their life for the future.

*“Being a girl child I can imagine how she is feeling now, and when she grows up how she would feel mingling with other children. I feel very sad about the loss of her leg...because it is a permanent damage that has happened to her, so anytime I look at her, I cry...how do I explain this to her when she grows up?” MPP7*

This mother was particularly sad about the fact that her daughter may not feel accepted among her peers because of the long-term scars and stump from the injury. The prospects of living with a daughter who is scarred physically and emotionally for life also prompted some deep emotions in her. Her primary concerns were the irreversible damage caused to the girl and the possible future challenges of her daughter living as a physically disabled female. This factor is especially significant, given social attitudes towards people who suffer from some form of disabilities. The social stigma of changes to body image in the Ghanaian context affect the future prospects such as marriage, job acquisition and even access to social places.

#### *5.4.4 Expressing faith in God*

The expression of faith in God was a common phenomenon heard throughout interviews with parents. Parents relied more on their religious beliefs to cope with deep emotions and as well to feel comforted. They expressed trust in God to heal

their children. Some cried and prayed to God for healing and spiritual interventions in their children situations.

*“I am just relying on God because he is the caretaker, so when he takes care of us and we are well, we will go home” **MPP7***

*“I believe that God was going to do it, I really believe in God because, what he has done for me I cannot thank him enough, nobody had faith that my child will be well” **MPP3***

*“I feel that if the child will survive or not, will depend on God” **FPP1***

*“By the grace of God, it (wound) was healing” **MPP1***

Although praying openly on the ward was allowed, it was not incorporated into the formal medical and nursing care duties. For example, considering the religious and practices of the majority of Ghanaian population (see section 1.5); one would expect that some religious activities like prayer sessions for the sick would form part of the daily routine of care. Parents reported that they prayed with their children alone by the children bedside. Some parents fasted and prayed to facilitate a speedy recovery. In Ghana, Christians believed that fasting is a way of prayer, which brings about quick results. Fasting and prayer were common among parents in this study.

*“We prayed on our own; when you wake up you say your prayer with your child” **MPP3***

*“So even if I look at it, I know that at least my child’s leg is healing or not and if I have to pray, I will” **MPP8***

*“Even if it is my prayer or fasting, I will do it just to make sure she is fit again”*  
**MPP12**

Some parents said they were “*consoled*” by the word of God from strangers and relatives. This made them stay happy and comforted and they had hope for their children’s future.

*“Oh, when I come and it is Sunday people do console me with the word of God which encourages me a lot. Others also advise me to thank God for everything that has happened. Although a lot of money has been spent I should thank God that they are alive and have the future ahead of us”* **FPP2**

*“I am happy because the word of God comforts me”* **MPP4**

A mother whose child was discharged and awaiting to go home attributed her child’s healing to the help of God.

*“God has helped us to be discharged today”* **MPP11**

Participants said even professionals consoled them with the word of God. Sometimes when the anxieties and fears of parents were obvious, professionals tell them to have faith and trust in God that their children will get well. Some asked parents to support medical efforts with prayers.

*“A male nurse came to tell me not to mind them (nurses) and that I should have faith and trust God and that he (the child) will be well”* **MPP3**

*“...The doctor went on to tell me that I should back them with prayers”* **FPP3**

Religious utterances and the practices of one's faith is a way of life in Ghana. It is a value thought in almost every home and even recited as part of daily greetings. It was not surprising that parents sounded religious throughout the interviews, and even cited some professionals doing it. In this research, the act of expressing faith in God was very frequent and important. In most cases, it was the only alternative way to feel reassured when no succinct information about the child's progress was forthcoming from the health professionals. Parents were asked to support professionals with prayers, of course, were vague, ambiguous and not enough information to help manage their overwhelming emotions. However, most parents reported that prayers and expressions of their faith in God helped them to cope with stress in the hospital.

So far, parents in this research reported the negative perceptions that people speculate about those whose children are involved in RTAs. Mostly expressions of child neglect, inadequate and poor parenting were sentiments and remarks reported. Some parents accepted the blame and experienced guilt feelings. Parents raised concerns about the challenges of child supervision and complex parenting skills in general. Other parents opted to blame families, drivers, institutions and even hidden forces by way of self-defence. Irrespective of the causes of the accidents, parents in this research were worried about their children's poor health. They feared to lose their children to death. They expressed sadness and anxiety.

Largely, findings from the first subcategory; managing emotions increased the parents' desired to stay in the hospital with their children. Fear of being subjected to public criticism about poor parenting was paramount. Staying in the hospital with the child was, therefore, an indirect and subconscious way to avoiding blame and verbal onslaughts. Some of the parents felt guilty and personally responsible for their child's accident. Parents clearly expressed overwhelming desire to stay informed about their child's progress, and to provide care as a way of assuaging any feelings of negligence. Consequently, parents became sensitive to other comments about the incident, especially the opinions and judgements statements from staff and other persons in hospitals. The next section presents the findings on parents' act of care to the hospitalised child.

## 5.5 Parental care roles

Parents were asked, *"What do you do for your child here in the hospital?"* Responses revealed the various care roles that parents performed in hospitals and their motivations to participate in such care roles. In addition, the challenging conditions in hospital environments such as the shortage of nursing staff among others compelled parents to support care provision efforts for sick children. The subcategory of **parental care roles** was coded and described under three sub-headings, which emerged from data. These were *providing comfort*, *"needed to fill in the gap"* and *physical care*. The next sections present descriptions of these codes with supportive verbatim quotes from parents' interviews.

### 5.5.1 Providing comfort

Parents described their anxieties and perceptions about the intensity and agony of pain that injured children experienced. Consequently, the parents reported that they use some comforting strategies to minimise the pains and sufferings of their children. Words such as “*pamper*”, “*comfort*”, “*console*” and “*sorry*” were mostly used. Pampering a child in the Ghanaian context means providing constant reassurance in a calm and soothing tone, agreeing to nearly all of the child’s requests, and utilising every possible parental strategies to provide both physical and emotional comfort for the traumatised and distraught injured child.

*“She was mostly crying that it hurts, so I pampered and comforted her, I told her sorry and to stop crying and that the pain will soon lessen” MPP2*

*“I also pampered him whenever I am fanning him... assuring him that it (pain) will all be over soon” MPP6*

*“She cried often at night...that the leg was painful...I pampered her” MPP8*

Parents also used strategies such as “fanning” to distract the child and in most cases convincingly prevented the children from prolonging crying. Parents in this study believed that the warm temperatures of the wards might have been discomforting to the children and perhaps making their pain worse. It was evident that all the wards had faulty ceiling fans.

*“Some of the ceiling fans are faulty, others work yet do not generate any air, and some are noisy and rusty”...the heat here is unbearable...it worsen their pain” MPP2*

Often, pain is described with words such as burning, pinning and itching due to the subjective nature of pain experience. The children descriptions of the intensity of pain as reported by their parents were subjective. Parents could not substantiate these, but rather invented the ingenious means of providing the hand fanning to give the children some distractions and comfort.

*“Yes when we came here initially, he used to cry a lot that it hurts and also itches”*  
**MPP7**

*“She also complains of burning pains in her leg so she cannot move the leg”*  
**MPP11**

*“Yes ever since she came here she has never raised her head, she says the pains are like some pins in the head”* **MPP4**

Other parents related their mere presence to providing a source of comfort and consolation to the child. Mothers reported that their presence alone “*consoled*” children in pain, and the encouraging and reassuring words they say to the children gave them hope. Parents also responded to the demands of the children in order to make them stay happy.

*“We needed to be around in order to console her because she is already suffering and not seeing her parents around will cause her much sorrow. However, when she is in pain and she sees her parents around that consoles her. The more you encourage and reassure her of speedy recovery whiles you are with her, it gives her hope and she does not even realise she has spent more time here”* **FPP1**

*“Once I am here and able to get her what she wants...because that is what makes every child happy”* **MPP10**



*“They need attention and pampering, so when you are with her and she is in pain because of your presence she is able to control the pain a bit” FPP3*

The parents, both mothers and fathers alike seem to be positively motivated to remain in hospital with their children to provide comfort and ease their pain. It highlighted the idea that the absence of parents may aggravate any undesired conditions of the sick child. Reassuring words from parents provided comfort, encouragement and hope for a child in pain. Some mothers cited different reasons for which parents provided comforting care to children. According to some parents, children have difficulty in opening up to nurses; thus, a child may be in need and not be able to communicate his or her needs to the nurses due to fear.

*“If they (children) need something since you are the mother they can easily say it...they are comfortable with us mothers... Or maybe if they are hungry they can easily tell you, but they might be afraid to tell the nurses...we mothers buy for them (children) what they want, so as to comfort them (children)” MPP10*

*“...because the mother cannot be here always, I make sure that I’m here throughout the day. I know it is not everything the child can say to the nurses. Sometimes my daughter behaves shy or something...I got her a small phone which she uses to call me anytime she needed to tell me something” FPP1*

They said that children might even be afraid to tell the nurses that they were hungry. Thus, parents considered their presence as an obligation for which some parents took turns to ensure that at least one of them was constantly present in the hospital. The parents further reported that lack of play items on the wards was another reason children were upset when left alone without their parents.

*“...I have to spend about 20 Ghana Cedis on toys for my child already. I bought a doll which she plays with when she wakes up... there are no toys here for the children” MPP2*

A number of activities were identified as comfort measures that parents provided to the sick child in hospitals. These were their mere presence, reassuring words, fans to cool off the children as well as diverting the child's attention from pains. It was realised that all parents perceived that children require the constant presence of parents by their bedside to remain comforted as well as effectively communicate their needs and pain.

#### *5.5.2 “Needed to fill in the gap”*

Apart from providing comfort to the children, parents reported that nurses, on several occasions called parents at random to do one thing or the other for their child. This situation described the circumstances whereby parents were not stationed on the ward with their children and yet their services were needed constantly. Consequently, the parents said they always had the sense of “*being needed*” to do something for their child. Many cited instances when they were called to calm the children when they cried. Parents also cited instances where doctors handed out daily prescriptions to go and buy medications for their child.

*“There are times that I am called to buy either food or medicine for her...they needed us (Parents) in times like these” MPP6*

*“...So I ensure that I am always around, in case I'm needed to settle the hospital issues... because I might be called back when I leave” MPP12*

*“Sometimes they need more hands to help dress the wounds, so they call me when am around to help them, especially when they don’t have enough staff” **FPP3***

*“If some of the parents of the other children are not around I fetch water for the nurses to clean up the children...more help is often needed on this ward” **MPP10***

The findings showed that parents’ help was needed to get supplementary foods for children despite that the hospitals provided daily meals to children on admission. They further assisted with wound dressing and in rare cases fetched water when taps ran out of water. Parents in the hospital were not only useful to their children, but to nurses and children of other parents as well.

*“...The child was crying and they (hospital staff) told me to stand by him... so you see when I’m needed? ... I stood by him and played with him...” **MPP1***

*“Very often, we are needed to fill in the gap for nurses and even for other parents who for some reasons may be hear with their children” **FPP1***

It is obvious that the parents were often not stationed in the wards with the children; they were called at random to assist with care. This substantiates the parents’ perceptions that their presence was crucial to fill in gaps in care. This raised many questions that were probed from professionals’ perspectives.

### **5.5.3 Physical care**

Parents reported that it was their responsibility to give parenting care to their children in the hospital. They described the care type they gave to the children, which were mainly physical care components. Physical care such as basic

hygiene care, grooming, serving child with bedpans and changing nappies were identified.

*“In the mornings I dressed him up and wash his dirty clothes, then around 12 pm I try to get him some food” MPP10*

*“If you are around you will bath your child...” MPP5*

*“We do not bath him, we wiped him instead” MPP6*

*“When it is time for me to clean him up I do it and change his clothes” MPP6*

To “wipe” a child as used in the above quote refers to giving the child a bed bath with the use of less water. Most parents were of the view that nurses could concentrate on carrying out nursing procedures, in other words, technical procedures that parents could not do for their children. Parents cited the administration of medications, both oral and IV as typical examples of nursing procedures parents cited.

*“I would want the nurse to do the things that I am not capable of doing, like medication, injection...things that they are trained for” MPP2*

*“The nurses themselves gave the children medications so all we do is to clean our children and dress them, it is better this way. You do not need to be a nurse to learn how to clean your child. This is what we do always...so they nurses can focus on the complex care” GPP1*

Despite the parents’ call to nurses that they must focus on complex nursing care, some parents admitted that nurses would carry out basic care for a child if a parent were not available.

*“When you are not around, the nurses will bath for the child, but what happens when the children are many...definitely, you will be needed...” **MPP5***

*“I do almost everything for my girl, the mum comes very early at dawn to bath her, but when she is unable to come, I plead with a nurse to help me to bath her” **FPP1***

Although parents agreed that nurses could give physical care to children, they were concerned about nurses having too many children to care for. Where the father was the basic carer for the child in hospital, the nurses' physical care for such children was required. Fathers perceived that some aspect of care, such as bathing the child was strictly a female responsibility for which only the mother or a female nurse was allowed to do for the child. Parents also recounted instances whereby the nurses taught mothers some nursing care to give to their children in hospital. Maintaining body hygiene, toilet care and grooming were some of care tasks nurses taught parents to do for children. Although parents could do these nursing cares being taught at the hospital, it necessary as some of the parent had to deal with the plaster of casts, traction and wounds for the first time.

*“They (nurses) taught me to do the dry cleaning with sponge and soap and clean with a wet towel using Dettol (antiseptic). They also taught me how to put on pampers (a brand of nappies) and other things so when they are not around I am able to do everything on my own” **AP***

*“They came to wake you up and tell you that look for the medicine for 5ml, 25ml, because they have written it on the bottle to give your child ...we were taught to give the correct dosage” **MPP3***

According to the parents, it was mind baffling that some nurses actually taught them simple hygiene care. Many of these comments were expressed by virtue of the fact that parents in the first place were not fully accepted in the children's ward. Yet the same nurses made a turnaround to ask the parents assistance to

give nursing cares to their children in the hospital. It also reflected that parenting in the hospital was expected to take a particular form for which all parents were given some orientations.

*“Initially we were not allowed in, but we persisted, we kept sneaking in and after few days, you become accepted. The nurses themselves will even call you to teach you the way to clean the child” AP*

*“It’s like having to force your way in unlawfully before they start to be nice to you. It was terrible at the beginning, but now the nurses are friendlier. Sometimes I wonder why the change in their initial stance, because these days, they go around looking for us to come and be with our children” MPP10.*

In addition to hygiene care, parents helped to feed their children. Sick children were mostly spoon fed by parents. Under normal circumstances, parents usually assisted children to eat at home especially in the case of the children who may not naturally like to eat their food. Parents’ services became more needed to feed sick children who were experiencing pain and discomfort.

*“Everyone here feeds their own child, as for feeding, the nurses don’t even have the time to feed all the children” MPP1*

*“She cries a lot during feeding and I think because of the pains from the injuries. So I take my time to feed her” MPP4*

Some parents did not see themselves being useful enough concerning the task they performed for their children. Either these were when the children were in a critical state or their fathers were supposed to be their main caring parent. For example, a father who stayed with the child said he only served the child with

bedpan; however, this was not an exceptional incidence because culturally, most men in Ghana do not get involved in the basic for children.

*“I do not do anything. I only serve her with the bedpan when she wants to empty her bowels or urinate” **FPP3***

*“She is in a critical state I think...I only sit here to watch her...she hardly opens her eyes, she is not allowed to eat yet...she wears diapers...I really don't do much for her...” **FPP8***

Nevertheless, a few other parents also reported that they were engaged with other tasks in the hospital, which was not directly related to the care of their child. Such other tasks included the maintenance of ward hygiene and cleaning of some hospital equipment. Parents complained that such additional duties made them tired despite the understanding and cordial relationship that existed before such duties were taken up.

*“I am really tired...I sometimes help to clean the ward when the staff are late then I jokingly tell them I will report them to their superiors. I clean the bedpans and help in most duties on the ward, I am very free with them and so I help them with the cleaning” **GPP2***

*“...The best way is to be nice with the staff, they are overwhelmed with the work so sometimes we help them. Especially in the evenings, the cleaning staff closes early. We the mothers help to keep the ward neat...it is sometimes difficult but knowing that your child contributed to the dirt, you just have to help” **MPP4***

*“We mothers are responsible for keeping the visitors' washroom tidy. There is only one toilet here and anytime a mother uses the toilet, she must make sure to clean the place. It is not always convenient but that is how we can also help the staff for the sake of our children” **MPP1***

Parents provided hygiene care to their children. Bathing, grooming and assisting children with toileting care were mentioned. They also helped with feeding the children. Thus, parents were actively and intimately involved in the routine care of their injured child in hospital. However, fathers' cares were restricted by gender specific roles rooted in the cultural norms. Nevertheless, parents, both mothers and fathers alike demonstrated their willingness and desire to continue their parenting roles in hospitals. They preferred nurses' interventions only when the care tasks are complex and required professional skills such as the administering of medication and wound dressing. Furthermore, they assisted to care for other children whose parents were not readily available. Parents went beyond childcare to provide services to maintain sanitation of the children wards.

## 5.6 Challenges encountered

Parents encountered many different challenges when giving care to their children in hospital. These challenges were mostly limitless hospital rules and principles that existed rather in unwritten form. These include regulated visiting times, nurses preferred parents in hospital and roles parents were allowed to carry out for their children. Furthermore, parents mentioned some negative attitudes of nurses as another source of challenge during their stay in hospital. Additionally, parents reported about the meals served to the children in hospital and overall care cost of child's hospitalisation was a burden. This subcategory is presented under five codes; *visit schedules*, *being sent out*, nurse attitudes, hospital *meals* and *care cost*.



### 5.6.1 Visit schedules

The parents reported a variety of visiting policies, which seems to be structured and unstructured. The children wards somehow had structured visit plans and rules for parents, other family members and significant others. Specific times of day, mainly early morning and late afternoon were allotted to parents and family visitors to the children in hospital. It was perceived that these visits times were scheduled purposely to avoid family interference during clinical procedures. Thus, parents were often allowed to see their children when no clinical activities were ongoing on the wards. Parents reported that they sometimes sneaked inside the children wards against the visit rules.

*“They told us that the normal visiting time is one hour early in the morning and also in the evening, about 4:30 to 5:30. But we the mothers could also come in for another one hour at 12:30 in the afternoon” MPP5*

*“Well, they said it is their policy that only the parents could come in the afternoon. This was just to give food to them (the children), otherwise, it’s early morning or in the evening, an hour for each visiting period” MPP2*

*We are allowed to come inside at 7 am in the morning and leave at 8 am. Then 12 o’clock you can come back and stay until evening. I stay until its 9 pm when everybody had left, after I try to coax him to sleep then the nurses will come and tell me it’s time to leave” MPP10*

*“...the mornings by 7 am, but from 6 am onwards you can start visiting your patient but after 8 am you will not be allowed. Let’s say around 3.30 pm that is when you start to visit the sick in the evening, so by 4 pm or 5 pm you have to start leaving ward” MPP1*

Enforcement of the visit schedule was somewhat relaxed after the afternoon visit as mothers could stay much longer until night time. However, this arrangement was strictly for only parents. Some parents reported strict enforcement of the

rules. When visit times were over, nurses rang bells or clapped their hands to notify that time was up. According to parents, ensuring that visitors leave the ward promptly denied children the full company of families and friends

*“...For instance, when it is time for visiting, they will allow you, but if the visiting time was over, the bell rings then you have to go out” **FPP3***

*“...when the bell goes they are not allowed to come in, sometimes when you start to enjoy the company of your family and friends, then the nurse on duty comes clapping hands to say time up” **MPP2***

Some parents reported more relaxed visiting rules, but they were not allowed to sleep in the hospital wards with their children.

*“When we were admitted they told us at the nurses’ table that nobody is allowed to sleep inside with the children so when I leave I go and find a place and sleep” **MPP1***

*“The nurses said that we were not supposed to sleep here...” **FPP2***

*“They said the hospital does not permit us (about sleeping in the hospital)” **MPP2**.*

However, parents in the other hospital reported a different policy in respect of overnight stays. It was identified that one of the hospital allowed mothers to sleep in the children’s ward overnight, which was not always in the case of the other hospital.

*“...If they had asked me to go home, I will not have been able to sleep. But because I am allowed to stay with him, whatever happens at night, I am aware of it. So I will say it helped” **MPP1***

*“Most of the time I am always around, we are asked to stay out of the ward only during the day when the doctors and nurses were working” **MPP6***

The parents' accounts indicated that the hospital where parents were not allowed to remain on the ward at night did not go home. Rather, they found places to sleep outside the children's ward. In the second hospital, despite the same fixed time for visits to the children, parents there were permitted to sleep in the children's ward at night. Parents said sleeping on the ward during the night gave them opportunity to keep watch over their children for any eventualities and that was helpful.

A child visitors to the children wards was another issue raised during the parents' interviews. Friends and classmates were not allowed to make visits to the hospitalised children. Even siblings were not allowed to visit their brothers or sisters in hospital. The nurses enforced this rule strictly.

*“They (nurses) said that children do not come here, because some of the children wanted to come here, but because they said children are not allowed...” **MPP3***

*“...I have a 1-year-old baby but I have left her with my mother, because they said children should not come here...it's not easy...” **MPP9***

No specific reason was given to parents for preventing child visitors to the hospital. One parent speculated that it was a strategy to control the number of visitors on the ward.

*“...Oh, no reason...maybe they do not want a lot of people here...it will bring a whole lot of issues...” **MPP7***

Concerns were raised about the application of the hospital rules. Parents said there was always confusion due to the inconsistencies with which different nurses applied the rules regarding visitation to the ward. Some parents reported that nurses sometimes gave them some stern looks, which communicated their displeasure about parents and relatives presence on the ward.

*“Everyone here and the way they do things. There are some nurses who will look at you in a way to say you must leave the ward...sometimes we know it, that it’s off the visiting hours, but...the look is sometimes very scary” MPP4*

*“Yes there was a time my wife’s brother came here at an odd hour, and according to him my daughter needed something... but the nurse gave him a bad look and did not mind the child either” FPP4*

Again, concerns were raised about visit time being too early and inadequate particularly for parents who came from far distances.

*“Yes, I really struggle to get here early, and I am coming from a far distance. Sometimes you manage only to arrive when visiting time is over” FPP4*  
*“It is not fair, sometimes my siblings come just after an hour, they are asked to leave the ward” MPP6*

Participants spoke about the frustrating nature of rules regarding visit time, especially for parents who held the perceptions that due to the critical state of their children’s, parents were always needed all round the clock. They were of the view that nurses “*could relax the rules*” since parents’ services and inputs were required during care.

*“...Sometimes even teachers and classmates wanted to come with me to visit her, they can relax the rules...even my neighbours wanted to visit, but the time is too early for them” FPP1*

*“...They can work around it” **MPP6***

The parents' concerns over visit rules in hospital revealed a communication gap between the parents and health professionals. The rationale for keeping parents out of the ward at certain times was not clear to the parents. Furthermore, it seems the rules were not applied equally. Some parents reported injustice, as they perceived differential treatments in the application of the hospital visit rules.

#### *5.6.2 Being sent out*

Among the leading challenges parents reported was being asked to leave the children's ward sometimes, unexpectedly. Participants reported that during painful procedures for children, parents were often asked to stay out of the ward. Parents said they were sent out of the ward even when children cried for the presence of their parents. Parents' reports reflect a sense of feeling powerless to negotiate their presence when nurses decide to send them out of the ward.

*“...we are not allowed to go to the children when they cry and when we go to console the children, they (the nurses) hurl abusive or cheeky and rude words at us. And when that happens we are not able to reply in anyway, since they (the nurses) claim to be more knowledgeable and we are also at their (the nurses) mercy we don't really have much to say” **MPP2***

*“Often we are asked to stay outside and come in when it's time...hmmm... I do not really think about it anymore since they say it is one of their rules. There is nothing anyone could say...” **GPP1***

Parents were not allowed on the ward during nursing procedures. The above account revealed that parents were obliged to obey the authorities of the nurses

even when it went against their desires. According to parents, defiance to go by the rules attracted abuses and rudeness from nurses. Another participant reiterated that nurses have disregard for parents.

*“Some of the nurses speak to us as though we were nothing worth their time...”*  
**MPP12**

Participants described their sleeping places during the night when they were sent out of the ward. Most parents said they slept in the open space outside the children ward at night.

*“At night, we sit outside because they won’t let you sleep with them”* **MPP2.**

*“I always sit around when it gets to the evening then I sleep outside around the outreach centre I just put a rug there and sleep”* **MPP10**

*“Because there isn’t any place where you could sleep at night that is why I would have loved to do it that way. But because there is no money, that is why I stay here; and also because my child has not being in such a situation or place before and she’s been crying asking me to come sit with her, but the nurses told us that it is not allowed per their rules”* **FPP3**

Meanwhile, in one of the hospitals, parents were allowed to sleep in children ward during the night, although sleeping conditions were not very conducive. Parents reported that they were expected to find their own mats or other objects to spread on the bare floor to sleep on at night.

*“I sleep on the floor beside the child on a student mattress to enable me to take care of him early in the morning before the doctor comes”* **MPP1**

*“We have a place to sleep but the mats are not provided by the hospital; we bring our own mats. When we sleep here they do not complain, we are free here so it is better than those at emergency” **MPP6***

*“I slept here I have just folded my pillow and my mat into my travelling bag” **MPP8***

*“At night I could not get a place to sleep I always sat in the chair so they told me that, there is no place to sleep but if I had a cardboard, cloth or bed sheet, I could lay it on the floor” **MPP3***

Parents who could not afford sleeping mats, they sat in plastic chairs by the bedside of their child at nights. They were not allowed to bring beds or mattress to make sleep comfortable due to lack of space. Personal sleeping materials allowed have to be an easy to fold and hide material for easy package every morning.

*“Sometimes they say if we think we can’t endure it then we should go home, sleep and come back the next morning, but for some of us the transport fares, both in and out of the hospital daily are a whole burden on its own. That’s why I think it doesn’t really matter...” **MPP2***

The parents reported that the staffs and institution were ambivalent to parents’ complaints. The hospital staffs’ approach was more of “take it or leave attitude”. Parents perceived that staffs were not engaging enough to listen to their daily concerns and complaints. Nonetheless, some parents commended doctors for inviting them into the ward during such unexpected times of the day and during medical procedures.

*“The doctors do not mind at times, but it is the nurses who normally sent us out” **MPP10***

*“Besides some doctors invited us in” MPP11*

The parents' accounts indicated that some parents disobeyed the rules when their children cried, which indicated that there were moments of tensions and conflicts for which parents ignored the consequences for the comforts of their children. The reports also revealed that nurses were mainly the health professionals who sent parents out of the ward during medical procedures and at night. On occasions when parents were allowed to sleep on the ward with their children, sleeping space and bedding materials were inadequate. Where parents were not allowed to sleep on the children's ward, they find obscured places within the hospital environment to spend the night. This shows the parents' commitments for childcare in hospital.

#### *5.6.3 Nurse attitudes*

Parents raised concerns about differences in opposing attitudes of nurses and doctors. Most parents expressed that doctors were more positive in their attitudes to parents than nurses were.

*“The doctors are always nice...I don't know if it's their training” FPP4*

*“Some of nurses are very quick tempered, so when you meet the ones who are friendly and nice towards you, you can ask them questions, but those who are harsh towards you, you cannot approach them” FPP4*

Parents rated the professionals' attitudes based on their approach toward parental involvement in the care of their child in the hospital. Physicians were



rated better in attitude because parents reported that doctors invited them to the wards. According to a mother, the doctors even mediated on parents' behalf when nurses were rude to them. Parents had the perceptions that nurses were impatient, quick tempered and harsh in their choice of words during communication.

*"...the doctor asked why she (the nurse) said that to me...the doctor rebuked her (the nurse) and she accepted her mistake. She does not have the patience to handle people" MPP9*

*"...the way she (the nurse) acted was not nice. We understand that we do not have to interrupt when the doctors are attending to patients but she could have done it in a nicer way... their choice of words is harsh and awful" MPP10*

Other parents felt that nurses disregarded them and took them for granted. These sentiments were reported because parents perceived that nurses exhibited suspicious attitudes, which was indicative to the parents that their low educational background were exploited and used against them.

*"It is because of the English they speak...so they think we don't understand...we do..." MPP4*

*"If someone has not been to school before and has brought the child here it does not mean that they are not human...they must listen to us, treat us well, sometimes they took us for granted" MPP3*

The parents perceived that because of their low level of formal education nurse were generally not nice to them. Some negative attitudes that the parents identified included poor interaction and communication skills of the nurses. They

also revealed that medical doctor were more accommodating to parents than the nurses were.

#### *5.6.4 Hospital meals*

In both hospitals, children were served with food three times in a day. However, parents complained about the quality and taste of the food. They reported that their children disliked the food and often refused to eat when served.

*“They are fed 3 times daily” MPP8*

*“They provided food but the food was bad so I did not take food from them; even when I take the food, the child does not eat so there was no need. I always buy food for him” MPP12*

*“She does not like the hospital food; she says it’s bitter sometimes” MPP4*

*“...the food is sometimes not delicious, so when they bring it we do not eat it; we threw it away almost every day” MPP9*

However, parents said children preferred some food to others. Children often ate the non-fermented breakfast such as cocoa or hot chocolate drinks with sugar and milk served with doughnuts or bread. Rice and meat meals were also most preferred for lunch and dinner. However, these meals were not served regularly. Furthermore, there is no system to allow children to order their preferred meals.

*“...sometimes when they bring food like the Jollof rice it is good and my son too likes Jollof and once there is chicken to go with it, he eats it. But as for their “Kenkey” with palm nut soup, yam with groundnut soup and stew, he does not like it” MPP4*

*“The only good food they serve here is their Jollof rice, and sometimes the bread and cocoa drink in the morning. Most of the children like those ones, but sometimes it is served just once a week, that’s all”* **MPP7**

*“...I go across the street to buy her rice balls with meat and soup anytime they serve yam or “kenkey”* **GPP2**

“Kenkey” is a traditional food of the Gas, made from fermented maize dough and boiled in cornhusk. Parents said that they complained on a few occasions about the hospital meals; however, reports indicated that either their complaints did not get to the appropriate staff, or the authorities were just adamant.

*“Yes, we complained to the nurses and the ladies who dish the food. What they said to us...that they just go for the food to serve, they cannot influence the food choice and quality...and that if the food is bad...they have just been sent to serve the food...you don’t really know who to complain to”* **MPP5**

*... Those who serve the food are not the ones who cook it; we have the kitchen staff there, even if you complain they will tell you as for them they were just asked to serve it. Therefore, if you complain it is ignored. So if you think you do not like it, you do not eat and whether you take it or not, you will still pay for it anyway”* **MPP1**

Irrespective of whether child ate the hospital food or not, all parents were billed for meals and were obliged to pay feeding cost in hospitals.

*“Whether you like it or not you shall be billed with it so whatever you do with the food does not matter even if you choose to throw them away... this makes no sense to me”* **MPP8**

It was identified that the quality of the food served to children was a general concern to all parents. Parents often brought food from home to supplement meals served to children in the hospital. Parents perceived that without the

supplementary food they provided, children would be hungry in hospital; hence, their presence in hospital was crucial in providing food to the sick child in hospital.

#### 5.6.5 Care cost

Financing care cost of the injured child was complex and challenging to many parents. Different sources of financing treatment cost were listed including the National Health Insurance Scheme (NHIS), out of pocket payments from drivers and owners of vehicles that knocked down the children, donations from relatives and friends. Apart from the NHIS, the other sources of funding care cost were not reliable and hence could not be factored in during the course of planning care. It was anticipated that a child registered on the NHIS would receive care without additional out of pocket pay. However, staffs' demands for cash deposits and payments for medication and these were sources of stress for parents.

*"Since we came here I have not seen much benefit of the NHIS except that the day we came here we were asked to pay a deposit of GH¢300.00 but we were later asked to pay GH¢150.00 because he had health insurance. Apart from that I have been buying all the medicines with prescriptions...it's not clear about the benefits of the insurance here" **MPP8***

*"Even with the insurance card, they still asked us to pay additional GH¢ 300 as deposit, but I told them I do not have...so am waiting...when we are discharged they will bring the bill then we would know what that money is meant for..." **MPP11***

Parents said the NHIS covers some medications and they had to buy others with cash, which were rather expensive. At the hospitals' pharmacies, parents could not buy prescribed medications with the child's insurance card. It was revealed that hospital pharmacies did not accept NHIS for medications purchasing.

*"The insurance covers few medications and when we came here she was not eating so she got stomach ulcer. The insurance covered the medications for the ulcer but it does not cover the haematinics... I don't understand how the insurance works" MPP5*

*"...the pharmacy does not accept insurance, and their drugs are very expensive" I don't know why" MPP8*

*"The NHIS does not benefit me much over here, except for the dressing of wounds. It covers only for few things over here so I personally do not see the benefits. I spent hours in queue only to be told the drugs are not covered, they would keep the prescription forms and will not even indicate the drugs I bought with my money...these things are not clear to us" MPP11*

*"They only give you the prescription but I do not know if there should be any note accompanying it that it should be covered by the health insurance. However, I believe once they write the prescription for you, you have to buy it. We do not normally want to probe into matters like that" FPP2*

*"He has NHIS...but when they request for the medicine, I have to find money to buy it...now I owe some money at the pharmacy and the theatre which I have not yet paid. They said the insurance does not cover everything, which I don't understand" MPP9*

Parents described the financing aspect of health care as very worrying and a burden. They relied on family members for money as loans and gifts to pay hospital bills. Some parents reported that they have no source of financial support, however, they expressed hope that their financial situations may change before discharge from the hospital.

*"I called my brother this morning wanting to know if he could get some money for the medicine but he said he is trying to get a loan from someone so until he gets some money we cannot go home...then we will still be here...hmmm, it's a big burden" MPP7.*

*“For now I am very worried and scared because I don’t know what figure (bills) they will mention to us at the end” **GPP1.***

*“I was just borrowing and my siblings also helped me with finances till the recovery of my child” **MPP12.***

Some parents expressed contesting views about some itemised charges in hospital. For example, a parent expressed concerns about having to pay for the doctors’ report for insurance claims.

*“So after paying the hospital fee, we would have to pay the Gh¢ 500 before we can get the medical report...I don’t get this, we pay for so much and one do not even understand it” **MPP4***

Parent expected financial support from the drivers who hit the children but in most cases, the drivers were not cooperative. Some drivers contributed unappreciable amount of money at the initial stages of child hospitalisation and stopped. Others never showed up at all in hospital.

*“They processed the accident case to court, the court asked the driver and car owner to pay a sum of Gh¢ 500.00 (about £90)” **MMP2***

*“The driver has been here once to see the child but since then he has not stepped foot here...regarding the child’s bill, the car owner said he will pay only GH¢ 500 (about £90), but he does not have any money so that is why we are still here” **MMP6***

*“The driver claimed the owner of the car collected the car so he comes around once in a while to give some money. About GH¢50 (about £10) which is not enough” **MMP8***

The findings revealed that apart from NHIS, various uncoordinated and unreliable financial sources were identified for the care of the RTA injured child in hospital. Commonly practised in Ghana, most commercial drivers do not own the vehicles they drive. Usually, car owners employ private drivers to run business with the vehicles. Hence, when an accident occurs both the driver and the vehicle owner are financially liable for the care of the injured victims. However, there is always misunderstanding about these financial arrangements towards the injured because of the lack of formal contracts between drivers and their vehicle owners.

The findings so far revealed the challenges parents encountered in the hospital as they care for their injured children. The structured visiting times to the sick child in the hospital was a burden parents reported. They were also asked to stay out of the wards during procedures and during the night as reported from one of the hospitals. Furthermore, parents reported that children did not enjoy most of the hospital meals served, and as a result, some children were not eating the meals served. Meanwhile, the cost of meals in the hospital was not negotiable, all parents were expected to pay irrespective of whether their child ate or not. Challenges including demands for cash deposits and cash for purchasing medicines were reported. Finally, the attitudes of nurses and medical staff were other issues of concerns to parents. Generally, it is perceived that nurses showed bad attitudes such as impatient, harsh in communication, and undermining parents due to the low educational background.

## 5.7 Negotiating the system

The fourth subcategory that emerged from the parents' interviews described some daily behaviours and attitudes that parent adopted to negotiate the medical system. These are described under three codes; *getting to know someone*, *exchange of favours* and *being appreciative*.

### 5.7.1 *Getting to know someone*

Parents reported that in cases where they knew someone who worked at the hospital, be it their friends or relatives, it was easier to manage some of the things that concerned them. Parents recounted their experiences, in terms of how such informal relations significantly influenced early diagnosis of the injured child, prompt treatment, and the prospects of receiving financial support from well-wishers on the wards. One parent talked about how a doctor identified with her by virtue of her hometown connections. She believed that the doctor attended to her child quickly because she came from the same hometown as the doctor.

*“A doctor came on his rounds and asked me where I come from. Then he said he is also from Ejumako then I also replied I was also from Mankessim, so he asked me what happened to my child and I told him that a car knocked him down. So he went to call a certain doctor and they came to take shots (photographs) of the leg with the computer, after which they told me that on Wednesday they will take the child to the theatre” **MPP1***

The towns of Mankessim and Ejumako are in the Central Region of Ghana, and share a strong historical bond, as well as speak similar versions of the Fante dialect. It is perhaps one of the expectations of parents to find staffs to associate



with for a quick service or some form of preferential treatments. Such practices are commonplace in the Ghanaian society, where tribal affiliations are still very strong, and tend to influence how those who provide services relate to service users in every sphere of endeavour. This same parent expressed satisfaction after she met the doctor several weeks after the first encounter. According to her, the doctor reassured her again.

*“Again, I met the doctor we saw the day we came here and he said that he is from Ejumako, he reassured me during conversation that my son’s leg will be fine and that nothing will happen to it since he is little it will be fine...that was at least reassuring” MPP1*

Other parents shared similar stories about how the family and friends who worked in the hospitals assisted in averting what rather looked like a delayed diagnosis for children.

*“We went back and forth between three hospitals; finally, I called my uncle who is one of the big men at Burma Camp before we got admitted here. ...even when we came initially, they said there was no bed. However, with a command from my uncle....we had bed. My husband is a Senegalese.....if I was not a Ghanaian, I am not sure my son will be surviving now ...hmmm here He (child) has been here since; when my husband went to call him (doctor)...before he was attended to...it is always whom you know” MPP9*

*“Well...this is our second admission; all the nurses became my friends from the first admission when the accident happened last year. Because of that, I can go home and I know my daughter will be fine even when am not around.” MPP7*

These accounts showed that parents felt more comfortable if they knew someone or there was some connection with a member of staff. It was a way to cope in desperate times when their children were in critical state and help was needed. It may be difficult for people without any such relationships yet, in such situations,

there were other strategies such as establishing rapport with a staff and offering to help with errands in the hospital.

#### *5.7.2 Exchange of favours*

The parents cited several instances they received support from nurses and doctors. Practically, some families were in hospital without any form of external family support by virtue of geographic locations of their extended family members or there were actually no external families. Such instances were easy to identify by the lack of visitors to the sick child in hospital. In addition, it was obvious that medical prescriptions for such children were often kept for days and weeks without money to purchase such medicines. In extreme cases, some of the parents open up to professionals for assistance and support to meet their personal needs. For instance, one grandparent participant explained the financial support nurses gave to her. She received cash support from nurses to purchase food. Her grandson was transfused a pint of blood through the nurses' arrangements and support to her.

*"I do not have any help.... so the nurses are the ones who helped me even with food to eat and the blood for transfusion for my grandson. I was supposed to get two pint, but the nurses got one for the child. They also gave me money to buy food" GPP2*

In Ghana, a patient in need of blood has to present a donor for replacement before a transfusion is set up. Patients often presented families or pay token to private volunteers who may be not related in any way to the patient. It is, however, a challenge to patients without family supports, because sometimes what was

referred to as a token was still unaffordable for some patients. It was therefore a huge support from nurses to arrange for donor replacement in the scenario above. Other participants recalled many instances they had support from doctors.

*“I was asked to go and buy medicine and I did not get some so I came to ask the doctors and they told me they had some and they gave it free to me” **MPP6***

*“I am grateful to the staff in this ward because they have done very well. The doctors are considerate. The other day I was asked to buy some metals to be used for my son. Another doctor came to review it and offered something else because the metal was too expensive” **MPP8***

The above reports on rare medications and expensive medicines are not rare in Ghana. Typically, pharmacies are individually owned and managed without any coordination and collaborations between hospitals and the private pharmacies. The hospital pharmacies are often under supplied with a limited range of drugs. Consequently, doctors prescriptions may be either difficult to get or at an unreasonable price for the average Ghanaian to afford.

Some parents reported that they also returned a helping hand to support their favourite staff by way of accepting to carry out additional responsibilities of the ward (see sections 5.5.2 and 5.7.2). Such ward duties include cleaning the ward, doing errands and helping care for other children. Parents perceived that such reciprocal gestures increased their chances of acceptance to the ward and improved relationships between parents and nurses.

### 5.7.3 Being supported

Following the support and care parents received from the professionals, a few participants said that they openly expressed appreciation for the nurses' hard work and the care they gave to their children in hospital. Their expressions indicated that parents were appreciative when nurses show caring attitudes to meet individual patients' needs. They indicated that the idea behind the show of open appreciation was to gain future favours from the health professionals.

*"I am sometimes surprised and thankful; because you will come from outside to find a nurse by her side conversing with her and fanning her just to console her. Whenever she is in pain, the nurses come around to chat with her so it takes her mind off the pain. And the way they handle the children is heart-warming; they are doing everything humanly possible. So far, I know of many hospitals but I can confirm they are doing very well here both the male, female, the senior staff and junior staff. Even the senior staff talks to the patients with respect; they are doing very well and I always thankful to them, they should continue the hard work"*  
**FPP1**

Parents described doctors as free and open-minded with patients' relatives. Some said they were dedicated, understanding and gave all their attention.

*"The doctors are very free and open-minded with us"* **MPP1**

*"I have also observed that the doctors in "XXX (name omitted)" hospital are very dedicated and give all the needed attention"* **MPP12**

*"Doctors are very understanding and patient compared to nurses. God help nurses to have the patience to look after our children and relatives"* **FPP3**

Similar attitudes were attributed to fewer nurses. Nurses were perceived to lack compassion due to complacency.

*“As for the nurses, I cannot really tell whether they have the compassion because they have been seeing this kind of situation almost every day so I would say it looks normal to them” **MPP12***

Mothers supported each other to deal with challenges, such as a mother asking for assistance from another mother to observe her child as she goes to carry out errands. Some mothers even fed other children in the absence of their parents.

*“I always ask the other mothers to keep an eye on my grandchild. For instance, there is a place across the street where I go to take my bath. Anytime I’m going, I ask the lady beside her bed to keep watch over her until I come because she cries a lot” **GPP1***

*“I sometimes help feed other children when their mums are out of the ward, the children don’t have any problem with me feeding them because I’m always playing with them...” **MPP3***

*“At the early stages of our admission, I couldn’t sleep. I was always sitting in a chair by the bedside. In fact, the other mothers helped me to relax. They advised me to ask my family to bring me a student mattress to put on the floor at night.” **MPP4***

In other cases, the parents offer listening ears to each other. They discussed challenges and issues concerning their welfare. They said talking about common problems was in itself reassuring.

## 5.8 Summary of findings from the parents’ interviews

Overall, the core category parental presence emerged from the interviews conducted with parents after the data was analysed. The four subcategories; managing emotions, parental care roles, negotiating the system and challenges

encountered, altogether developed parental presence. It was widely reported that the child's sudden injury, the hospital admission, and clinical procedures, of which some were perceived painful to the child, and parents coming to terms with their child's injuries all contributed to different emotions that parents expressed. Thus, the emerging subcategory, managing emotions emerged from codes such as, blame and guilt, anxiety and worry, sadness, fear and hope and expressing faith in God.

The hospital, which was perceived as a strange and unfriendly environment to both children and parents required some form of negotiations to facilitate care. Parents mostly negotiated for their constant presence in the children's wards. The negotiation strategies were individually done in an uncoordinated basis, using the influence of social status and organisational powers. Thus, parents used their social connections to source public figure influence on the health professionals, which gained them constant access to their children.

The subcategory of parental care roles emerged from the perceptions that parents' presence in the hospital often provided them with the opportunity either to perform some care task, for the sick child or to assist the professionals. Parents' presence alone was also viewed as a source of comfort to children in hospitals. Furthermore, parental touch, prayers said, and the primary care parents engaged in for the sick child contributed to the emotional well-being of children admitted to the hospital. Parents by virtue of their presence offer them the opportunity to stay informed about the progress of their child's treatment.

Also, the ability to continue parenting in the hospital contributed to parents' emotional management and satisfaction with care.

Although most parents perceived that parental presence benefited the child and parents in the hospital, the parents' constant access to the children wards to provide the comfort and care to their sick child was not as straightforward as expected. The subcategory challenges encountered outlined the nature of difficulties parents encountered and reported. These included professionals' attitudinal related reports, open visit schedules and care cost related reports. For example, the visiting policies of hospitals and children units that were unclear serve as impediments to parents' continuous presence at the children units. In addition, parents had to prove their worth with the evidence that they could keep the cleanliness of the children units and to assist to carry out errands for the health professionals.

## 6 Chapter 6: Findings- family involvement

### 6.1 Introduction

Having outlined the parents' perceptions of the hospital care for injured children in the previous chapter, this chapter presents the nurses and other professionals' perspectives. The chapter is divided into four sections; the first section presents the demographic characteristics of health professional participants followed by the presentations of the core category, family involvement and its' four subcategories. The third section presents the summary of the findings presented in this chapter; lastly, the fourth section outlines the conceptual model uncovered for the care of the injured child in the hospital.

### 6.2 Demographic characteristic of parent participants

The findings presented in this chapter emerged from data gathered in twenty-four (24) interviews with health professional participants as presented in table 6.1. The majority of nurses who participated in the research were general nurses. Only two of the nurses were trained as paediatric nurse specialists, although it was anticipated that many more of the nurses could have specialised in either paediatric nursing or trauma nursing considering the recent availability of training in both speciality training in Ghana. Nonetheless, most of the nurses had an appreciable number of years of work experience on the children surgical and orthopaedic wards. The participants' minimum length of experience in children



nursing was two years and the maximum was thirty-five (35) years. Two participants were paediatric nurses, three nurse midwives and a public health nurse. As noted in Table 6:1 below, the nurses were made of more females with only two male nurses.

Table 6.1 Health professional participants involved in individual interviews

Category	Number	Identification (ID) code
Female nurses	13	FNP1-FNP13 (Nurse participant)
Male nurses	2	MNP1-MNP2 (Male nurse participants)
Nurse manager	6	SNP1-SNP6 (Senior nurse participant)
Orthopaedic surgeons	3	OS1 & OS2 (Orthopaedic surgeon) OS3 (Paediatric Orthopaedic surgeon specialist)

Apart from three of the nurses who were single, one had divorced, one a widow and all the others were married. Six of the nurse participants had no child and the rest had children ranging from one to four in number. It was evident that the parental status of nurses and the expedience in nursing ones' own sick child in hospital influenced the nurses' perceptions and practice of parental involvement. All three orthopaedic surgeons who participated in the research were males. Two of them were specialists and one a consultant. They are married and have children. All professional participants are Christians from different ethnic backgrounds in Ghana. Religious backgrounds of participants influenced the mode of care. This phenomenon is expanded in detail in the research findings. Table 7.1 shows that the participants involved thirteen female nurses (13), two male nurses (2), six nurse managers (6) who were all females, two Orthopaedic surgeons (2) and one (1) orthopaedic specialist. Identity codes used in this

research to ensure anonymity of the categories of participants were; Senior Nurse Participants (SNP), Male Nurse Participant (MNP), Female Nurse Participant (FNP), Orthopaedic Surgeon (OS).

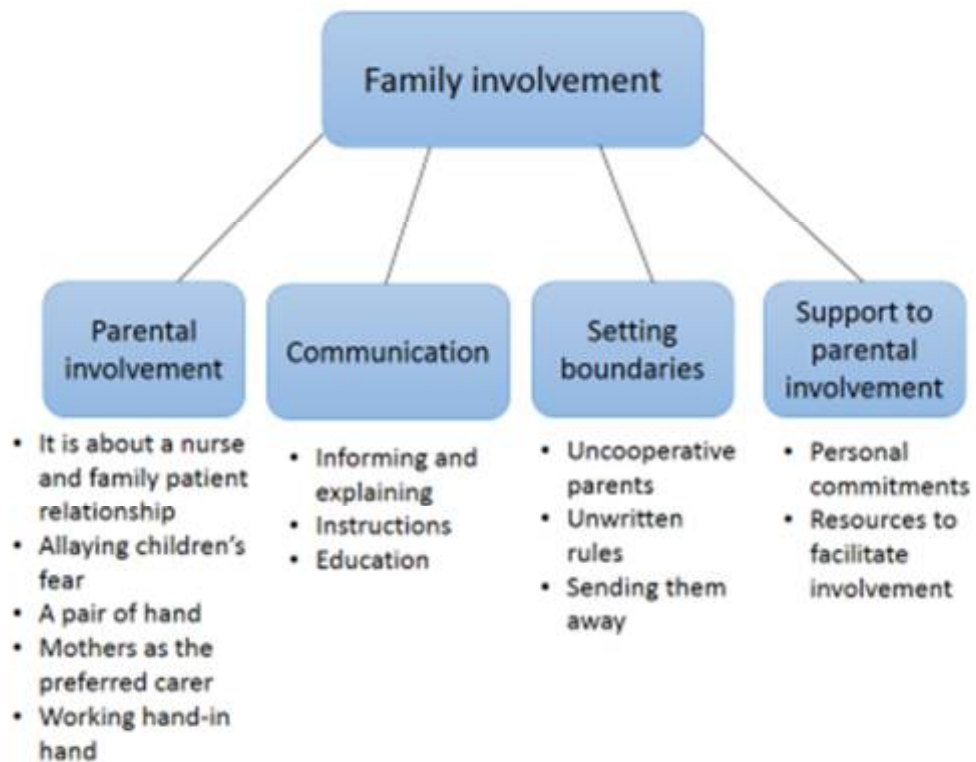
### 6.3 Family involvement

Following the opening question “What happens to the child victim of RTA at the ward level?”, the health professions in this study described the care process as a continuation of the care given from the emergency department. Similar to the responses from the parents, all the nurses in this study recognised RTA as an emergency condition, which is traumatic for both the child victim and families. Codes that emerged from the professionals’ data generated the core category, **family involvement**, consisting of four sub-categories, *parental involvement*, *communication*, *setting boundaries* and *support to parental involvement*.

*Parental involvement* emerged as the first subcategory. This subcategory presented the degree to which nurses worked mostly with parents in the caring process and not necessarily the entire family. There were different forms of interactions between nurses, medical professionals and parents mainly described under *communication* subcategory. Besides, nurses protected, defended and enforced their gatekeeping role presented in the subcategory of “*setting boundaries*”. The compassionate aspect of the nurses and medical professionals emerge and presented in the subcategory “*support*”. Figure 6.1 presents the core

category of **family involvement** and subcategories and the dimensions and relationships.

Figure 6.1 Professionals' perceptions of family involvement



## 6.4 Parental Involvement

Parental involvement was the initial subcategory that emerged from the nurses' interviews. It refers to the nurses understanding of the term FCC, which, directed their actions and inactions regarding family participation during care to the injured children in their new hospital environment. The perceptions of nurses about the children's condition and their reactions to hospitalisation contributed to parental involvement. In other words, nurses encouraged increased parents' involvement

when they perceived that the children's condition was serious and critical. In addition, mothers were mostly the preferred family carers due to environmental constraints for both children and parents. Furthermore, experiences of nurses determined the extents of parental involvement. Parental involvement emerged in five codes. Thus, *"It is about a nurse and family patient relationship"*, *"Allaying children's fear"*, *"a pair of hand" mothers as the preferred caregiver* and *"working hand-in-hand"*.

#### 6.4.1 *"It is about a nurse and family patient relationship"*

All the nurse participants preferred to describe their understanding of the concept of FCC at the initial stage of interacting with them. Their responses further informed the directions of subsequent discussions. According to nurses, FCC is the same as family involvement. Among many of such descriptions were "family being involved in care" and "involvement of the family" or "relatives".

*"Family centred care talks about the family being involved in the child's care when the child is hospitalised. It is not about a nurse and patient relationship. It is about a nurse and family patient relationship"* **SNP6**

*"...It is the involvement of the family in the care of the child"* **FNP1**

*"...as you care for a patient we usually involve the family, in paediatrics especially you cannot care for a child without either parents or the guardian, you need them"* **SNP5**

*"...family centred care is to involve the family or the relative in the care of the patient. What I especially know is, in children, if possible if the parents can even stay around"* **FNP9**

*“...when you involve relatives or patients family members in the care of patient”*  
**FNP4**

*“I believe FCC has to do with seeing the individual patients as just not a patient. But then the family that the patient is in. So it will be beyond treating just a patient to involving family in the patient's care”* **SNP2**

The term “involvement” was the key word in their descriptions of the concept FCC. Although many of the nurses explained what they meant by involvement, they were not very emphatic about whether all professional practised it or not. Moreover, they also seem hesitant to comment about its full application in clinical practice.

*“I will not say we practice the FCC well, although we involve the relatives who come around, I will not say we practice FCC”* **FNP11**

*“Well...FCC is not practised here per se, but if I were in the position to make decisions, I may consider it. It's probably not the priority of the DDNS now.”* **FNP1**

*“...we do FCC to some extent. It may not be the complete FCC, but parents are involved in care especially the mothers”* **SNP3**

It was obvious that FCC was not a common terminology used in Ghana. Family involvement was the widely used terminology. The nurse manager (A Deputy Director of Nursing Services -DDNS) appears to decide and direct the practices in respect of family involvement on their units. Nurses reported that involving the family began right from the day of admission and continued throughout the entire period of the child's stay in hospital.

*“Right from the beginning you admitting the patient you need to involve the family because from the history you need to know exactly what happened to the child”*  
**SNP4**

*“...you involve them in all steps that you take the child through, so they also have a say in whatever is been done for the patient. They (parents) also took care of the patients just as the nurse takes care of the patients”.* **MNP1**

The nurses considered the process of history taking as the start stage of family involvement and it continued throughout the caring period. Nurse MNP1 viewed parents as equal partners in care and their views were equally important at every step of care. However, only a few nurses had similar views and understanding. Some professionals related the ability to practice FCC to professional experiences and the background of ones' nursing education.

*“You see if you work abroad okay you cannot help but notice that the families are really involved with the care of the children...I had my paediatric orthopaedic training in Toronto Canada, and...parents were really involved in their child's care...there FCC was well understood and practised”* **OS1**

*“...because where I had my training at Agogo (one of the nursing colleges in Ghana), we had evidence of children not doing well when we sack their parents. So since then, in the 1997-96 when I join this hospital I do involve parents in care...”* **SNP3**

*“Hmm...I had the opportunity to do paediatric specialisation so I understand FCC. I think my colleagues will appreciate it if there is some sort of training for them”*  
**MNP1**

The participant OS1s' experience in a Western culture influenced his perceptions and understanding of FCC practice. The place and period (year) of training were factors, which contributed to participants' perceptions and practice of parental involvement as articulated by SNP3. Although not directly linked to this study, she

went ahead to describe her experience with nursing children in the past. According to nurse SNP3, during the late 1990s when cases of child malnutrition were common among children in Ghana, it was easy to identify the signs and symptoms of children who were lacking parental care and this had since influenced her perceptions about parental involvement. These findings directly relate to the background findings of professional participants of which majority appeared not to have had any form of speciality training after the general nursing training. It was clear from the above findings that those participants who were experienced and had speciality training in paediatrics reported to have had knowledge about FCC and that their units were not fully practising FCC.

#### *6.4.2 Allaying children's fear*

Nurses reported that at the initial stages of admissions, children cried and wanted their parents to be by them most of the time. Thus, the nurses perceived parental involvement would be of help to children to cope better with hospital situations. They also had beliefs that children were more receptive to the nurses' attention when parents were present. The nurses reported that children were not comfortable with hospital admissions. They often cried that they wanted to go home. This was characterised by screaming and wailing anytime nurses approached them.

*"Immediately we came close to him he would start shouting because he was afraid of us. You can just imagine if the mother was not there. They feel at home when their parents are around. If the parent is going out to buy medicine the children will be crying" MNP2*

*“...even common feeding some children are afraid to let you come close to him or her. Children do not allow the nurses to feed them, they hate to see the uniform person, well I don’t know why so” FNP5*

Children could identify nurses by their uniforms and probably relate the uniform to unpleasant procedure or events. Some nurses held the belief that some parents trained their children to be distrustful of strangers and the fact that not everyone could be trusted to provide genuine care.

*“Some parents instruct their children not to eat from certain people (strangers)” FNP1*

*“There are children who will not allow any other person to feed them apart from their parents; I want to believe that their parents trained them that way” FNP7*

In the case of the nurse and child patient relationship, nurses were total strangers to children. Again, regarding strange environments, there were cases of children admitted to the adult wards due to reasons such as lack of space for such children at the level of adolescence to teenage years. This was a common practice in both hospitals. The nurses in this research reported that the practice of mixing children and adults together in the same ward was a bad practice that contributed to the children not liking the hospital environment very much.

*“After 12 to 13 years depending on the child’s body size, we refer the children to the adult ward...I don’t think the children like that environment that much” FNP5*

*“...sometimes some of them feel that their ages were not here much or they are limited to the older stuff...and even because they may not be closely placed in the ward, talking to each other, playing together is a problem...it negatively affects their stay here” MNP2*



*“Because they are mixed with adults, they feel a little shy to talk about their challenges and problems so their conditions keep deteriorating” **FNP7***

It was revealed that children above age twelve were nursed in adult wards. At the time of collecting data for this research, both nurses MNP2 and FNP7 were nurses who were caring for children on the adult wards. They reported that the atmosphere of the adult ward did not promote effective communication among children. Children could not communicate with their peers, and neither their needs to nurses effectively. They were also limited in play activities. According to the nurses, this hindered the children's recovery.

#### *6.4.3 “A pair of hands”*

Some nurses expressed the views that the involvement of parents in the care of the children was more of the lack of sufficient nursing staff rather than a true commitment to the concept of family involvement.

*“...sometimes the ward is big, we have a capacity of about almost 40 (patients) we are just about two nurses on the ward, two nurses cannot care for forty children at a shift... we need help...definitively we need a pair of hands” **FNP3***

Most nurses, including the orthopaedic surgeon mentioned the shortage in nursing professionals as a major factor in needing parents help with childcare in the hospital.

*“... We know there is general shortage of manpower, and so it with nurses, parent must help, we need help” **OS1***

*“It is a relief for us sometimes because we have a shortage of nurses. Imagine all these beds are occupied with patients? How can we allow all mothers to go out and then we have two nurses taking care of all the children? I mean you would need the mothers to be around to take care of these children” **SNP6***

*“With this shortage in nurses, you can allow the relatives to help. The in-charge will understand. Yes, management knows that we are understaffed and always need extra hands from relatives. So we ask them to stay in case we needed any medication or something, they come and help” **FNP6***

Shortage of nursing staff emerged as a common knowledge and therefore necessitate for parents involvement. This account relates directly to the parents' code, “filling in the gap”. Parents reported that they were often called at random to help in the care and that gave them the sense that their services would be required. For that reason, parents stayed in the hospital even when their stay seems unofficial or “illegal” in the hospitals' policy terms. Furthermore, the incapacitation of the child patient also required family help in giving nursing care to such children in hospital.

*“The family has to help us, yes we need them...for instance, a patient who is not able to do anything for himself will need a relative to help the nurse on duty” **FNP8***

Nurses outlined some activities parents helped with on the ward. Most of these were tasks that emerged from the parents' interview outlined earlier. Nurses described both physical care tasks that constituted basic care and that which were nursing care tasks.

*“...They (parents) will assist in feeding their children” **SNP2***

*“A relative can do the bath for a patient” **FNP2***

*“Like they do the bathing...sometimes when the nurse is bathing for other patients some of the relatives help” **FNP8***

The nurses also described the circumstances where parents were helpful in assisting with nursing tasks such as observing children for changes in condition, medication administration, wound dressing and care of IV infusions. During such nursing procedures, parents helped to hold the children still for the success of the procedures.

*“Sometimes also they may have seen a change in the child’s condition...they come and tell you (the nurse) that I have realised that my child is not breathing well. We rush to the bedside and attend to the patient, so yes they are helping out with the care” **SNP4***

*“When they are around it is very easy to perform some procedures because they usually assist us to make the procedures easier like giving medications, wound dressing and IV” **FNP1***

*“If something is happening to a child and most probably the mother is not even around but another mother might notice and inform us the nurses.” **SNP4***

The parents were thus viewed as helpful to children other than their own on the ward. It occurred that the parents’ acts of helping facilitated the nature of the relationship that existed between nurses and parents. A cordial relationship emerged as helpful in this sense.

*“...how we relate with the mothers also, allow them to assist us”. **FNP1***

*“When it is not visiting hours and we still need somebody to be with the kids mostly we call on the mothers or the parents to tell them that their help was needed...they readily help” **MNP2***

The nurses did not involve parents for the sake of the children needing the presence of their parents. Instead, parents' help was required to augment the caring efforts of nurses. Parents' help was viewed as a necessity and important in achieving both basic and nursing care. However, in most cases, the need for a helping hand was not a deliberate strategy but largely because the deficit in personnel was obvious, enough to inform parents to remain to provide the care they knew would be lacking.

#### *6.4.4 Mothers as the preferred caregiver*

The nurses asserted that family caregivers are usually involved in the care of children in the hospital, but in most cases, mothers were most preferred.

*“Usually we involve whoever the caregiver is, but most especially we prefer the mother to stay on and care for the child” **SNP***

*“Mostly we call on the mothers to come in to give care to their children” **MNP2***

*“With the children we do allow the parents, most of the time the mothers to stay with them during the night, almost 24 hours, the mothers are always with them” **FNP3***

*“I know that the protocol on these wards, we allow only females because they are closer to the children. We allow mothers, caretakers or guardians who are females closer to the child than males”. **SNP3***

The nurses cited the cultural role of women in the Ghanaian family settings as a reason for promoting maternal involvement. Mothers emerged as primary caregivers. It was a tradition that mothers from ages cared for children. There was a further assertion that children were closer to their mothers, hence, the hospital was to allow the motherly extended role of women to give care to the sick children.

*“Mostly you know in Ghana the mothers are more involved in the care of the children than the fathers so it is the mother who we teach to bath the child”* **PN7**

*“Since I started nursing, it has always been mothers going up and down the hospital and the fathers will go to work come and visit once a while to provide the necessary money. So I prefer the mother I am more comfortable to work with the mother”* **SNP1**

Although mothers, naturally and culturally were inclined to care for children, nurses also reported that they were more comfortable working with mothers. There was evidence of some level of tolerance for fathers as well.

*“We do not restrict parents to the visiting times. They can come in anytime either the mother or father”* **SNP3**

*“... Well it will depend on which parent the child is closer to but...”* **SNP2**

The nurses, however, reported some restrictions on fathers. Fathers' stay on the wards beyond seven o'clock in the evenings was unacceptable and discouraged. Some participants were emphatic that it was the hospitals' protocol to exclude fathers at some point at night.

*“...here on our unit, we do not allow the fathers to sleep but they can be here anytime but by 7 pm, he must leave the ward. The mothers can sleep here at night”* **SNP3**

*“Because of issues of abuse and lack of privacy we do not want the male parents to stay”* **SNP2**

The involvement of mothers as the preferred family members was well emphasised. Beyond accepting parents, mothers were most preferred with explanations linked to the Ghanaian culture. There was the perception that in Ghana women automatically accept parenting as their primary role. This therefore translated into the care of the sick child in the hospital. Besides this explanation, it was also obvious that inadequate resources in the hospitals limited the full participation of fathers. Hospital ward arrangements did not allow for privacy at most times. Children wards were big rooms divided into cubicles, but the divisions were such that one could always see others in their various cubicles. Keeping both adults genders of different backgrounds in the open space was demeaning to the female gender and unhealthy practice in the Ghanaian context, hence the fathers were discouraged to stay at night, but mothers were sometimes asked to sleep over. The physical presence of the mother alone emerged as parental involvement. However, parents were required to do more than just being present in the hospital.

#### 6.4.5 “Working hand-in-hand”

Finally under the subcategory of family involvement, is the approach nurses espoused to the nature of involvement. Nurses described the act of carrying out

a procedure with parents as a process of involvement, thus, they worked with mothers “hand-in-hand”.

*“...most of the things here are done hand-in-hand with the mothers because since their kids sometimes resisted when us from doing things for them. So most of the things like bath, feeding, mostly we did it hand-in-hand with the parents” **FNP5***

*“It was of great benefit to the children because they are familiar with their own parents and so they were more cooperative with the care that is given alongside with parents” **FNP11***

*“Sometimes when you want to give the suppository to the child, they prefer to have their mothers do it for them because they do not really know you, so when we want to do something and the child does not agree, we call the mothers to do it together with the nurse.” **FNP4***

The main purpose of nurses working hand-in-hand with parents was to gain the cooperation of the children. Nurses identified that when they worked together with mothers, children were more receptive and better behaved. They said children cooperated better when mothers gave certain care such as giving medications by suppository. Other instances where nurses conducted activities with mothers hand-in-hand were described. These activities were same as the physical care tasks parents reported in their interviews. Some nurses reported that involving mothers in routine care tasks assisted them to become more confident in providing care in cases where the child had a large wound or amputation. Such instances required nurses and parents working together to build the confidence of parents.

*“They help in their feeding, and also help in comforting them. We (nurses) also do but children feel more comfortable with their mothers. They also sometimes*

*help in cleaning, which is done together with nurses especially in situations that they cannot, due to fear, we assist them” FNP3*

*“...when a child is seriously injured, and let’s says there is a big wound or P.O.P or even amputation, mothers are often scared to handle their children. In that way, we nurses take it upon ourselves to do the bath for such children. The mothers will be there to help though” FNP1*

Getting parents to run errands in the hospital was another way nurses described parent’s involvement hand-in-hand. Most nurses mentioned that the buying of medications for the sick children and assisting children to X-ray departments for diagnostic investigations were main errands nurses cited.

*“...working together could be parents running around to get things necessary for the child care. For instance, we are sending a patient to the x-ray department a relative can accompany the nurse to the x-ray department and I think it is all part of the family involvement...” FNP6*

*“Sometimes the doctor may request an x-ray. We are few doing the work so we cannot send the children to the X-dept. The family has to send them” FNP8*

*“They (parents) come in the morning, afternoon and evening and most of the times if the child needed something it was the parents who got to buy it, it is part of working with parents...” SNP6*

The phrases, “*working hand-in-hand*”, “*alongside*” or “*together with parents*” were the strategies of parental involvement. The need to work with parents to supplement staff strength facilitated this move.

Parental involvement so far appeared because of the shortage of nursing staff, needing the assistance of parents, the strange and unfriendly nature of hospital environment and strategies to gain the cooperation of sick children. The clinical



environments were more receptive to females (mothers) than males (fathers). A cordial working relationship was necessary for parental involvement. Basic physical cares were tasks nurses cited that parents were comfortable to do. Other care tasks included nursing care such as medication administrations, wound dressing, the setting of IV lines and helping to take children to other departments for diagnostic purposes.

## 6.5 Communication

Communication was the second subcategory that emerged from the nurse's interviews. Nurses communicated with parents on different occasions and for different purposes. Communications under this subcategory were described in three codes. These were *informing and explaining*, *instructions*, *advice and education*.

### 6.5.1 *Informing and explaining*

Information sharing was one of the key purposes of communication between nurses and parents. Nurses reported that they are sensitive to parents information needs. They reported that families experience same anxieties just as the sick children; and the less information about the sick child increases their level of stress. Nurses perceived that parent's needs for information increases when they experience anxiety.

*"During admission when the patient has a disease condition or is undergoing treatment family members also go through some sorts of the anxieties that some of the patients go through and therefore requires information more than ever."*  
**FNP11**

The nurses used terms such as "informing", "telling", "asking" and "explaining" to describe the transfer of messages. These terms were used interchangeably.

*"...right from the beginning when you are admitting the patient you need the history, to know exactly what happened to the child. You get all these information from whoever brought in the child. You will involve the family by asking and they will tell you."* **SNP4**

*"...They {physicians} expect that the parents will tell us and then we will, in turn, tell them"* **FNP7**

The process of taking patients' medical history from the family at the beginning of care was one way by which information flows from parents to professionals. It was also regarded as a way of involving the family, and therefore nurses informed the family about the outcome of their assessments and what families should expect of care efforts.

*"...we are talking about a nurse informing the relative about everything that we have to do for the child or the patient..."* **MNP1**

*"...you tell them exactly what is wrong with the patient, they have knowledge about whatever goes on with the patient..."* **FNP4**

*"We normally orientate them; we tell them the rules (the ward rules)..."* **FNP13**  
*"It just getting the parents involved in the care given, explaining to them why you do what you do, and then the side effects or the implications of what you do..."* **FNP7**

The nurses sought mainly to communicate the child's condition to parents or the family carer and sensitise them on what to expect from health professionals concerning the child's care. Another key purpose of the information giving was to ensure that parents were aware of the hospital/ward rules. Most of the nurses added that they encourage parents to ask questions and make suggestions to professionals about their child's care. They could also inform nurses about observations they made on their children. Typically, these were strategies to get parents to express their fears and anxieties.

*"...Yes, parents can ask and suggest something, and based on our knowledge in our work, we inform them on the right way forward."* **FNP4**

*"We try to talk to them (parents) and give them any information they will need..."* **FNP11**

*"If they see anything different from what they expect, they can give us a feedback... that is how it works..."* **FNP7**

Nurses were explicit about the information they shared with parents. These included information on children's conditions, the expectations of nurses, basic routines of the hospital and possible outcome of treatments. In a similar manner, parents were encouraged to ask questions about their child's health and progress. Some of the nurses acknowledged that due to distressing reactions from parents, medical doctors sometimes carry out procedures without necessarily explaining things to parents. There was a sense of protecting parents from further distressing news about painful procedures carried on the injured child.

*"To some extent, we have some parents who asked questions about certain procedures that were performed on their children. But then the doctors would not explain the situation to them. So we advise the parents to open up and ask questions when the doctors come on rounds"***FNP6.**

*"We advise relatives on how to handle bad news about their sick patients...not all parents can manage distressing news about their children's health"* **OS2.**

The nurses reported that despite good advice given to parents, which aimed at supporting the child's recovery and well-being, it often seems like these advice were not followed.

*"...For instance, when you advise parents to see the physio staff with the children, they don't. They prefer to go home to continue with herbal treatments. ...Just last week, we had a mother who comes back with the child in a very complicated state. She never brought the child for reviews..."***FNP12**

*"Lots of children get discharged and continue to stay on this ward. If you advise them to go to the social welfare department, they will be dodging us. Parents sometimes played the hide and seek with us until finally, you will discover that they've absconded"* **FNP2**

*"We cannot do more than to advise them on the support systems like the social welfare and etc."***SNP2.**

The nurses reported that parents refused to heed to advice, however, these reports were unresolved communication challenges between parents and the nurses. The nurses' reports regarding such issues reflected a lack of alternative solutions to parents challenges for which nurses also felt unsupported and unable to help.

*"Well, it is their right to refuse or listen to advice; I personally think sometimes parents know what is good for them"***FNP13.**

*"It for the interest of their children, but they can take or leave it"* **FNP10**

Interestingly, the language of the nurses changed when it was the turn to get parents to talk to professionals and ask those questions about their child's conditions. The nurses used terms such as "advice" which sounded more persuasive. Furthermore, "advice" was also used to convey information that required parents to carry out a follow-up action; for instance, in cases where parents were required to arrange for physiotherapy and to attend follow-up clinic with their children. When parents failed to do so, it was handled as respecting parents' rights to decision making and the rights of professionals to advocate for the sick child become jeopardised.

#### 6.5.2 Instructions

According to the nurses and medical professionals in this study, instructions to parents served two main purposes. One, to give directives to parents and secondly to ensure that parents do exactly as expected of them. Giving instructions came up as participants explained their experiences with parents who did not heed to medical advice concerning their children. Instructions were therefore reported as a sure way of communicating issues for which staff were assured that parents would respond favourably.

*"...Every instruction you give to them they will stick to that (which means instructions were followed)..."* **MNP2**

*"When they understand the issues, especially the mothers, they tend to do whatever they can of course if it is not within their means, they cannot do anything. But I think... that is one problem that we have in this country in general. We do not take our time to explain to the patients what the issues are, what the child has, what needs to be done and then may be the consequences. I mean if*

*we do not do what is expected to be done then subsequently their mothers do not see the urgency of those things” OS2*

*“Yes I think generally, we always underestimated the intelligence or their capacity to understand these things, when you really explain to them, I mean you do not necessarily have to mention very technical terms, just tell them what the real issues are usually they do understand. Once they understand the instructions, they are more willing and ready to help” OS3*

Nurses reported that on few times they resorted to making referrals to another health professional with the specialist expertise to have better communication with parents.

*“So we had to refer her (clinical psychologist), there was a need to let her be aware of the need to allow the child to be fit for discharge” FNP7*

The efforts by different professionals to communicate on same issues to parents on their child’s medical condition required inter-professional collaboration. Effective teamwork to ensure consistency of the information given to parents was essential. Nurses shared sentiment related to the possibilities of parents receiving different information on the same issues. One nurse acknowledged the importance of documenting information passed on to parents and others. This is to avoid giving contrasting information to parents.

*“In some situations when the doctor comes in without the knowledge of the nurses, that is when the doctor could pass information on to the parent without the knowledge of the nurses. Some would document in the folder and tell the parent so then later the nurse can get to know what happened in her absence from the folder. So it is good doctors documents all information needed by the nurse” FNP1*

Information sharing between professionals and parents was one act seen as involvement, but could also create confusion if not done properly. Information sharing was perceived as beneficial and necessary for medical diagnoses, however, disharmony in communications sometimes occurs and can be problematic.

### 6.5.3 Education

Parent education in this research referred to that aspect of the children's condition and care that the professionals deemed parents must learn. Nurses reported that parents were educated on their patients' conditions and care. Although in some instances, information giving and parents' education were described in a similar manner and used interchangeably, there were slight differences between informing and teaching. Parents' education was aimed at parents learning new caring skills in order to help with childcare.

*"We give them every education and information that they need about their patient's condition" **FNP11***

*"Ideally, we must give total care but because the mothers are willing to help, we teach them how to dry clean the child without actual bath they do at home" **FNP5***

There were differences in views among professionals about the parents' ability to understand materials that required teaching. This came across when parents' performance with care did not meet staffs' expectations. Some professionals attributed these to the low educational background of parents. Others reported that the large population of patients and their parents affected the length of time

they could have spent with parents teaching. It was a genuine acknowledgement of poor quality teaching due to heavy workload on the aspect of the professionals.

*“Obviously my interaction with the parent is not as much as I have liked because of the large numbers and also the fact that their level of literacy is low”**FNP13**.*

However, other professionals held different views which recognised that the parents’ capacity to understand health information were underestimated. The accounts indicated that there were some elements of prejudgments among health professionals about parents learning abilities.

*“Yes I think generally, we always underestimated the intelligence or their capacity to understand these things, when you really explain to them, I mean you do not necessarily have to mention very technical terms, just teach them what the real issues are, and usually they do understand. Once they understand, they are more willing and ready to help” **FNP2**.*

Other professionals perceived that there were positive sides to parents’ not knowing much and hence trusting their entire child’s care into the hands of professionals. This suggested that these professionals were comfortable with the traditional medical model, where parents are not encouraged to participate in shared decision-making.

*“The parents who cannot read or write sometimes are better because they sort of trust your judgement so they defer all the decisions to you hoping that you give them the best care, it is one of the reasons that I take training of my residents very seriously” **FNP3***

*“...Because I mean you cannot cut corners... we live in an illiterate society and these parents are deferring decisions to the surgeons to make so they should get some value I mean, it is not like somewhere else that you say okay we have four*



*options and I want this one... I mean they have deferred everything to you that do the best for their children and therefore I mean you have to take that confidence invested in you seriously..." OS3*

When parents displayed what professionals saw as ignorance and put all their trust in the medical system, there is often the likelihood of practising a care that depicts one size fit all, and care delivery was actually in that manner. There were also the perceptions that parents' beliefs regarding disease causation influenced their acceptance of health teachings and medical advice.

*"There is that challenge of deeply rooted cultural beliefs, that is an impression is created that everything has spiritual ramification so when you try to explain things to them they know that there is a grandmother somewhere who is causing this problem so especially with the deformities. These deeply rooted beliefs make patient teaching very difficult" OS1.*

Despite the varied views on parents' education, the majority of nurses advocated for the need to educate parents especially on how they may be involved in their children care.

*"...if we are able to educate parents on how to conduct themselves I am sure they will participate in care effectively. There must be a continuous education. Currently, there is nothing of the sort, and I do not know if we even have space and the capacity to house them" FNP10.*

*"We need to present the information in a simple way, about their treatment, the therapy that they are receiving, drugs and other rehabilitative procedures that are carrying out here we have to teach them, so that when the patient goes home parents can continue with it smoothly" SNP5*

Besides all the above difficulties with parents as reported, professionals acknowledged that, not all parents were ready to learn new skills. Some nurses

perceived that often, parents did not understand things they were taught. It was further noted that learning new skills and being able to follow instructions was also not easy for parents who experienced confusion and anxieties.

*“...Either they do not understand whatever you have told them. So you will come and whatever you have told her has not been carried out well” **SNP4***

As part of the discharge process, parent education on the child's condition played a vital role in childcare, also an important tool for communication. There were divided opinions about whether it is worthwhile educating parents. Varying opinions speculated about the low levels of parents understanding of medical education on their children medical conditions. Some participants in the study suggested that there is the need to pay attention to content and words for teaching parents as they acknowledged less time for teaching and ambiguity of some materials taught.

## 6.6 Setting boundaries

Setting boundaries was the third subcategory that emerged from the interviews with nurses and medical doctors. This subcategory described the professionals' perceptions that parents had the tendency of being uncooperative and difficult. They cited instances when parents were likely not to cooperate with the health professionals, which had effects on interaction and care. Therefore, professional barriers were important to guide parents in their role performance in the childcare in the hospital. The barriers placed limitations on parental visits to the children's

units. Furthermore, a description of how the health professionals put uncooperative behaviours of parents under check is also outlined.

#### *6.6.1 Uncooperative parents*

Nurses' alertness for uncooperative parents was one of the leading challenges all nurses reported in this study. Nurses reported that there were many occasions of disagreements, confrontations and misunderstandings encountered between parents and staff. These were reported as uncooperative, difficult and problem parents and the ultimate end was conflicts in the children's wards. Arriving at a decision on the childcare was typical examples of the causes of conflicts mentioned.

*"When you are dealing with children, decisions have to be taken by both parents and professionals, or has to be consented to by the parents and so sometimes, that becomes a problem when you want to do something and then the patient's mother is not in agreement and sometimes we have a conflict there" OS2*

It was evident that the doctors sometimes perceive and desire for parents to participate in shared decision-making. However, there seems to be some element of inadequate information provision on the part of the professionals. This was reported that parents showed difficulty in their ability to follow instructions and their failure to learn new skills.

*"Sometimes some of the parents are not cooperative either they are not ready to help with the care you teach them." SNP4*

*“Some of the parents are very cooperative some are not, some do help a lot and I can say they do help us but some of them are just a problem to us, very problematic” **MNP2***

Nurses reported that a few parents were verbally abusive. These were reported as instances where parents did not agree with the orders of nurses and became provoked and abusive.

*“Sometimes, the patient's conditions do not permit a lot of people to be with the patient at the same time. There are times that you see relatives coming in, at certain times we may be engaged in certain procedures, yet when you ask them to stay out, they insult you.” **FNP3***

*“...then she (a mother) started insulting all of us on duty at that time...” **FNP7***

In other cases, nurses reported that some few parents' expectations were that nurses should provide all the care to the children in the hospital and therefore were not ready to contribute to their child's care.

*“... Some feel once she (the child) is on the ward and you have nurses around, it is the duty of the nurse to do everything, so some do not cooperate at all” **SNP4**.*

In addition, a parent is perceived uncooperative when she demonstrates having some knowledge about medications or care approaches, which seems inappropriate for the child. Nurses have the assumptions that such excuses from parents are often inaccurate.

*They (parents) read so some also think that whatever you are telling, he or her should be... and they do not cooperate. We had cases like that. Sometimes medications are prescribed for the kids and they felt that they do not want their*

*child to take such medications, probably she has read on it and knows the side effects of the drugs and sometimes they refuse medication.”SNP4*

Furthermore, nurses reported that long duration of hospitalisation was another reason parents became frustrated, irritable and uncooperative. Parents often requested for early discharge, sometimes against medical advice and when such requests were not granted, they became uncooperative or difficult.

*“A parent wanted a child to be discharged because she thought they have spent so many days in the ward. Apparently, the child was not fit to be discharged so we had to send the mother to see the clinical psychologist because we noticed she was not cooperating with assisting the care of the child, there were many of such cases and parents became difficult” FNP7*

Where parents' demands were perceived as extremely unreasonable or out of the usual, a third party was often involved. The clinical psychologists were usually contacted and involved. In some other cases, nurses and medical staff perceived that some parents actually required the professional assistance from the clinical psychologist due to behaviours they have seen as abnormal.

*“I think there is a certain element of confusion, anxiety, so you tell them something today then the next day you ask then they have forgotten everything you have told them or maybe they want to be reassured so they pretend that they do not remember” OS1*

The professionals sometimes also made the assumptions that parents were faking ignorance or pretending to forget the things they were expected to do for their children. However, few professionals were able to identify that what some of their colleagues perceived as pretence on the side of some parents were actually parental needs for additional information to be reassured.

There was clear evidence that nurses were not comfortable with family presence during nursing procedures. Nurses in this study considered disagreements between parents and nurses as challenges for which nurses labelled parents as difficult and uncooperative.

#### 6.6.2 *Unwritten rules*

Enforcing hospital rules and policies were among the many ways nurses and staff maintained order and discipline on the children's wards. It was also a way to avoid challenges and confrontations with parents. As earlier reported under family involvement, rules and policies were communicated to parents on admission. However, it later emerged that the rules and policies that nurses referred to rather became issues participants termed as "what we came to meet here", in other words, traditions of the hospitals and wards they inherited. Regarding rules related to family involvements, nurses shared opinions on the routines of their hospitals and the wards, which were presented under section 6.6.2.

*"I will say because of the policy that we have here; we do not allow the parent to sleep or stay on the ward 24 hours. Just allow them to come in and to see their children unlike other places that they allow the parents to be on the ward for 24hours and 7 days" FNP7.*

*"At the moment there is no policy that allows them to be around for long hours because now it is like everyone has to be around during the visiting time so I believe if there is a policy that allows them to be around" SNP2*

*"If the parents can even stay around, they should follow the rigid rules "the one-hour visiting time and 30minutes in the morning that is all for the day" FNP9,*

Whereas most participants referred to such routines as policies applied in hospitals, and that which they adhered to, some other participants had different opinions.

*“You can choose to restrict them (parents) to the hospital time. They can come at any time. The mother, the father comes at any time, but here we don’t allow the father to stay; only the mothers who stay. So the fathers can be here 8 am, 9 am but as soon as its 7 pm he would not be allowed to stay” FNP2*

A probe into the operational rules and policies of the various wards revealed that none of the participants in this study had ever seen any written policy of their hospitals for the entire period as the nursing staff of their facilities. According to participants, almost every rule and policies referred to were the nurse in-charges’ orders, or a routine or tradition verbally passed on from staff to staff.

*“Our in charges gave those orders, which are those who were here before I came. I do not know but I was told by mouth” FNP7*

*“That is what we came to meet and that is the routine that has been adapted” MNP1*

*“I really do not have the reason why it is so because I came to meet it as it is” FNP2*

Health professionals reported about the seemingly impossible hope for a change in ways of family involvement and general traditions of the hospitals. They shared their views on the lack of will power of the nurse in-charges to change those policies.

*“If you ask the DDNS now, all she will say is that she came to meet it but for her to effect the change, it will be very difficult for her. If I were in her shoes, I would have used what I have seen or what I have heard to restructure some of the rules and regulations. I mean with the current education ongoing, things are changing,*

*and we must be responsive to that change. But I do not know, for her (the nurse in-charge), maybe she may like the current situation, if not, it lies with her to be able to make a change if she really wants to do it she could do it”* **SNP6**

*“The thing about XXX hospital is that it is an elephant for them to make changes. It takes forever so that is the problem some of us have gone through it so we know”* **OS3**

One of the medical officers in this study had also challenged the essence of signing on to the rights of the child and yet not practising the kind of family involvement that was commensurate with the United Nations Rights of the Child.

*“In this hospital, there is a policy which says no parent, I have never understood why because I mean we have sign up to all those UN, United Nations, Laws, Rights of the Child and you know...but it is just on paper”* **OS1**

Nurses referred to rules or policies to maintain order on the children’s wards. Interestingly, there were no such documents regarding family or parental involvement in either hospital. According to the nurses’ accounts, they were practices they inherited and continued to enforce and hence, became the traditions of the units. Medical officers in this study also questioned some of these traditions and shared their frustrations about the difficulties in making changes in this regard.

#### *6.6.3 “Sending them away”*

Features associated with the barriers set for involvement include assuming control over care and supervising parents care activities on the children unit. Nurses perceived that children well-being in the hospital was more of their



responsibility and not the parents, and it is the duty of the nurse to ensure that whatever the family does to the child was in the best interest of the child and that it promotes healing. They also perceived that their control of parents' activities was necessary to assist parents in their new and unfamiliar environment. This highlights the perceptions of the hospital being a special place managed by only professionals. Therefore, perceived control over nursing care serves as a way of maintaining professionals' power in the hospital. Participants reported on several instances that parents were sent out of the children's ward when their services were not required. Nurses mentioned that parents were not allowed to observe in procedures being carried on their children.

*"It is okay if they will not interfere with our nursing procedures and I think when we need privacy we just ask the mother or the father to wait outside" **FNP9***

*"During procedures such as wound dressing and major ward rounds, we ask parents to go out" **SNP3**.*

Nurses stated several reasons for asking parents to stay away during procedures. They reported that some parents speculate false information and give false accounts of things they have not seen. These views were subjective and based on individual assumptions.

*"Because most of them talk a lot, that is what we have observed. You may be doing something and you think another child's parent had not seen yet by the time you realize he or she had seen the next is you would hear them talking about that child which we believe it is not fair, so unless it is necessary when we are performing procedure mostly we send them out" **SNP1**.*

*"The way they communicate among themselves; the patient relatives themselves and then one relative talking about the other's child. Mainly that is what brings about the problem" **SNP3**.*

*“Complaining to the other mothers saying things they have not even seen” FNP6*

The nurses also confirmed the families accounts that they were not allowed to remain on the ward overnight.

*“They sack them from the wards; the mothers are not allowed to sleep on the ward” OS3*

*“If one mother will just sleep here and give you a lot of troubles we will rather decide that she should go home so you will have your peace” FNP6*

*“To avoid arguments and confrontations we ask them to stay out of the wards. They only come in when necessary” SNP3*

Initially, nurses identified the many ways parents and staff had disagreements and misunderstanding. Typical of such were parents' inability to learn new skills to help in their child's care, demands for early discharge against medical advice and parents forgetting to carry out some care orders for their sick child in the hospital. Nurses went ahead to report their own speculations and assumptions that parents conveying wrong and false information among themselves if they are allowed to stay and observe procedures, which suggest elements of mistrusted relationships.

The health professionals in this study revealed that they often send the parents away during procedures and sometimes out of the wards at night-time, a way to avoid confrontations with parents. It was also reported that asking the parents out is a long-standing tradition of the wards practices, which is inherited in a form of unwritten rules and policies.

## 6.7 Support for parental involvement

Support was the final subcategory from the nurses' data. Nurses supported parents during hospitalisation of their children. The support described here revealed the many ways nurses placed themselves in the position of parents, as they felt touched to give sympathetic care. The different ways nurses and doctors supported parental involvement were presented and these were presented under the codes, *personal commitment* and *resources to facilitate involvement*.

### 6.7.1 *Personal commitment*

Nurses and medical staff related to parental involvement and reported a rethinking of how the approach to family involvement must be reconsidered in the future. These thoughts were reported as some of the nurses reflected on the parents' disagreements with the existing arrangements regarding parents' involvement in hospital care for children. As reported earlier, parents experienced mixed emotions about their children's health and wished to be involved in their care. Nurses were aware of parents' desires to participate in their child's care. Many shared personal thoughts and experiences of how they personally felt about parents in such positions of having to care for an injured child in the hospital.

*"I want to be around, I told you that I am a mother and I would not want my child to be here. I always think about this...that if my child is here and I am not around what will happen, I will not be able to feel free, I really feel for these parents and I share in the plights" SNP6.*

*"My son was admitted to the hospital in the past, I could not stay away, and maybe because I am a staff they allowed me to stay with my son. I think we are not fair to these parents, it's a shame" **FNP12**.*

*"...because it is not easy...I have a child myself and if you see your own child go through that trauma it will not be something pleasant... It is not possible for me to go home and sleep peacefully and come back the next day...I sympathise with the parents" **FNP7***

*"...because sometimes I ask myself supposing it is my child, how would I feel if I were in their situation. Sometimes I ask myself about how women who are here and in their menstrual period cope here. There is no privacy in here to allow mothers to have the freedom and space to dress up properly; some also have to leave their work to come and stay with their children and one may ask how they will cater for the child since they are not working now. So maybe excuse duty can be used for some days but for how long? I really do feel for parents" **SNP5**.*

The reflections of some of the nurses who showed personal commitments to parental involvement however, their accounts revealed some element of lacking control over the current situation. A few nurses recounted their own experiences as parents during their child's admissions to the hospital. They described how their status as nurses facilitated their ability to negotiate to participate in childcare. However, for non-health professional parents, such privileges were not available; indicating that there is the need for health professionals to initiate increase parents participation in care.

*"Personally when I see such cases I allow the parent on the ward and I wish all nurses will understand this and do same because it is not easy" **FNP9***

*"I think if there is any policy or schedules that can be put in place for mothers to stay around with the children, why not? They should stay around and take care of their own children that are the basic thing that they have to do" **FNP12***

*"You see if you work abroad okay...,you cannot help but notice that the families are really involved with the care of the children...that is how it must be...and I involve them all the time, even to the doorstep of the operating theatre...I wish our matrons understand this concept" OS1*

A few nurses explained their understanding and importance of the parents' participation in care. They reported that parents involvement have emotional benefits to parents and the child. According to the nurses, allowing parents to have constant access to children in hospitals was a way of emotional relieve to children, especially the younger children.

*I know the importance of parents to children, especially the very young ones. So the parents are always with the children and it helps a lot in the recovering of the children. That is why I will let them in" MNP2*

*"Where I was before coming to the trauma unit, I mean the children block, we do keep mothers in with children and things worked out perfectly. So I allow them, it keeps them emotionally stable." FNP3*

*"We let them stay and that is a form of psychological support" SNP2*

A participant reported that giving "counsel" to parents was another way to care for parents psychologically. Nurses reported that parents of seriously injured children were devastated and heart-broken. In such cases, the nurses counselling referred to in this report was actually a provision of additional information related to the child's progress and reassurance.

*"We talk to them, we counsel parents, and we gave them a pat on their shoulders. We assured them that it will be well with prayers" FNP11*

*"The use of other relatives of their family helps. We invite the most psychologically stronger person to talk to these mothers. Especially the fathers do well in this*

*perspective. Fathers are able to deal with bad news better, so they come in to support us in counselling the broken-hearted mothers” OSP1*

The findings above showed that nurses and medical staff recognised the emotional experiences of parents during their child’s hospitalisation. They supported parents emotionally by providing additional information, staying closer to parents to give them a pat on the shoulder, encouraging spiritual care as well as well as urging stronger family ties. It also came up strongly that the nurses and medical doctors in this research desired for a review and reconstruction of policies regarding parental involvement. This was evident as nurses shared their own experiences as parents, and revealed the difficulties of leaving their child in the care of hospital staff. The experiences of some professionals who worked with families in a western culture further made a difference in appreciating the need for a change towards an increase in parental involvement.

#### *6.7.2 Resources to facilitate involvement*

The hospitals were reportedly under-resourced, which allegedly hindered family involvement. Nurses reported on the lack of space for children and parents in the hospitals. The children’s wards were open spaces and divided into cubicles. Parents’ needs, concerning space, were lacking. Beds, mattresses and other beddings for parents comfort were not available on the children wards. There was no provision for feeding for the parents in the hospitals. Furthermore, facilities such as toilets and bathrooms were inadequate. For instance, ward capacities of 40 children have only one toilet for parents. These toilets are of low standard and

poorly maintained. Financial resources for medications and food were other areas needing support.

*“The hospital has to provide accommodation to relatives who are caring for their patients, the only facility available is not big enough to take them all” **FNP4***

*“Because they would need a comfortable place to sleep currently and I do not know if we have space and logistics, even the capacity to house them” **MNP2**.*

Nurses reported that some parents were supported from personal pockets. In addition, donations from individuals and organisations as charity to the hospitals were sometimes used to support parents and sick children in the hospitals. Doctors were sometimes helpful towards supporting parents financially. Besides the personal out of pocket support, nurses advocated for institutional support in diverse ways to improve on the state of facilities in the ward.

It was also identified that medical doctors especially and few nurses were frustrated by their inability to practice family involvement. They identified the lack of support from colleagues due to their lack of skills and knowledge on the benefits of family involvement. Staff shortage also demotivated the practice of family involvement to its best.

## 6.8 Summary of findings from the health professionals' interviews

In summary, the health professionals perceived that FCC means to involve the family in the care of children in the hospital. Professionals in this research were

more familiar and comfortable with the term family involvement instead of FCC. Critical analysis of the data gathered from the professional participants revealed that parental involvement was the actual practice as mothers were most active in childcare rather than the entire family. Even between parents, mothers were mostly preferred. Nurses reported that the professionals' preference for mothers over fathers was influenced by the cultural norm of childcare in Ghana, which perceive caring as a maternal role. Additionally, the available logistics in the hospitals was inadequate to accommodate fathers. However, giving mothers the opportunity benefited the children and professionals more than having the fathers in the hospital. It was reported that mothers were good at providing comfort measures to children in the hospital. Their presence enhanced the strange hospital environment to become friendlier for the children on admission. Mothers filled in the gap for nurses, as nursing shortage was acute in both hospitals studied. They assisted nurses with errands and care for the children.

Communication between professionals and parents was regarded as key to facilitating parental involvement. Nurses reported that history taking was the starting phase of information sharing and parent involvement. Information sharing, giving advice, instructing parents and educating parents were the four ways of communication identified in this research. Findings revealed that advising parents was one weak way of communicating with parents. The reason was that parents often did not heed to the advice. Instructions were more likely to be followed and desired results were gained. The issues reported as parent teaching and education were more like information sharing than education. Meanwhile,



participants reported that low educational backgrounds of parents made information giving and medical education challenging.

Nurses reported the challenges they faced with parents. They revealed that parents were uncooperative, difficult and problematic. Parents' inability to learn new skills, forgetfulness and not wanting to assist in care were such labelled as uncooperative behaviours. Others were gossips and peddling of false information among parents. The nurses reported that they applied the rules and policies of the hospital to check the difficult behaviours of parents. Meanwhile, the further probes revealed that there were no such rules, instead, what nurses referred to as rules and policies were traditions most nurses met at their wards and hospital. The nurses said they mostly sent parents out of the ward during procedures. In one hospital, parents and even mothers were not allowed to sleep in the children's ward at night.

The last subcategory presented the views of professionals in support of a rethinking and reconstructing family involvement for a better practice in the future. Despite the disparities in perceptions and practice, nurses spoke in favour of improving hospital conditions to aid family involvement. Mainly, institutional supports for policy and resources were mentioned.

## 6.9 A theoretical model of care for children involved in RTA in a Ghanaian context

The aim of this research was to explore perceptions of Family Centred Care (FCC) for children in Ghana, hospitalised through Road Traffic Accidents (RTA). Findings revealed that although the FCC concept is not formally established in Ghana, some common components of the concept reported elsewhere were perceived and practised irregularly during care. Thus, the model of care depicting the child as the central focus for both parents and professionals emerged as presented in figure 6.2.

Figure 6:2 A model of hospital care for the children involved in RTA



In the above care model, two opposite directional lines link the two major categories (parental presence and family involvement) that contribute to the care of injured children in the hospital. Similar lines link subcategories, which contribute to the construct of the two categories separately. The two broken lines in the model point to subcategories, which according to the data have elements that did not promote parental presence and family involvement respectively.

From the parents' perspective, **parental presence** denotes parents' desire for a constant physical presence in hospital, active involvement in the basic childcare and staying informed about all aspects of care. A parent in hospital emerged as the mother performing basic childcare duties and be supported by her male counterpart. Occasionally, other female relations such as a grandmother or an aunt could substitute for the mother.

**Family involvement** represents the perspectives of professionals regarding their understanding and practice of FCC. In the context of this research, **family involvement** embraced **parental presence** in principles but lacks deliberate attempts for implementation in practice. Evidence of **family involvement** was driven by individual professionals' goodwill efforts.

Parents' emotions and the quests to **managing emotions** following accidents and hospitalisation of the child form the foundation for **parental presence**. **Parental presence** gained approval through intense desire and persistent efforts. During the hospital stay, the inherent caregiving responsibilities of parents

were manifested in the hospital care processes. Progressively, the daily care needs of the child and staffing conditions of the hospital environment ushered parents into active participation in the care. Subsequently, inclusion in the basic caregiving and provision of comfort to the hospitalised child espoused **parental care role** as a key element of parental presence.

The professional barriers was the driving factor for negotiating the medical system to again access and remain in hospital with the child. Challenges in the care of the hospitalised child were inevitable. **Challenges encountered** emerged as significant barriers to **parental presence** and participation in childcare.

**Family involvement** was the professionals' understanding and practice of FCC but not necessarily practised in all cases. The evidence of **family involvement** in practice was driven by acute staff shortages and the need for external assistance to support caregiving effort to children in the hospitals. Maternal caregiving role from a contextual perspective underpins **parental involvement**. **Parental involvement** denotes the physical presence of parents, of which mothers were preferred in the hospital and progressively allowed to take up basic responsibilities of childcare. **Communication** is a core category precursor for **family involvement**. Information exchange foster negotiations and interactions between the professionals and parents to facilitate involvement.

The subcategory of **setting boundaries** represents the exercise of power and authority mainly by the nurse. Nurses exercised their gatekeeping role to control

**parental presence and family involvement.** Thus, the final subcategory, *support to family involvement* was the recognition to **family involvement**, which ensures that the process of involvement is moderated by the nurses desire to maintain control in the hospital.

It was also observed that the concept of parental presence and family involvement are not static models, as the constituting elements are subject to change over time. For example, the level of exhibiting both concepts may differ at different times of hospital admission. For instance, in this study, establishing rapport and building trust between parents and health professional was necessary for parental presence and family involvement. The influence of time factor in the practice of parental presence was evident under the concept of **negotiating the care system**. Parents reported that “*getting to know someone*” in the hospital facilitated their presence and this only happened over a period of time. Parents experience familiarity with people and procedures when they stay longer hospitals, and this enhances the role they play in childcare. It implies that parents who experience short stay in hospitals as in the case of most acute conditions will experience less family involvement.

In similar sense, nurses reported that they were reluctant to involve new parents in childcare. This was presented under the subcategory, “*setting boundaries*”. However, parental involvement increased as parents spent more time in the hospital. Particularly, considering the age of the injured child, the progress in

condition and the needs of the sick child were factors that enhanced family involvement.

It is also evident that family involvement is unlikely to occur in future if no conscious effort is made regarding its' continuous practice. This evidence is located under the subsections "*needed to fill in the gap*" and "*a pair of hands*" (sections 5.5.2 and 6.4.3 respectively). Both sections explained the practice of parental presence and family involvement because of shortage of nurses and clinical staff. This implies that adequate number of nurses and other clinical staff in the future may further decrease the current level of family involvement. Irrespective of the potential variations in elements over the time scale, there are observable factors, which influence the practice of the overall concept of family involvement. These factors are detailed in the Force Field Framework Analysis of family involvement under section 7.5.

## 6.10A contextual, conceptual model of parental presence and family involvement for the hospitalised child

The social construct of parental presence and family involvement is recognised in many research reports (Coyne et al., 2011; Hutchfield, 1999; Coleman and Smith, 2010; Coyne, 2015). The dimensions of parental presence and family involvement, explored by various authors provide different perspectives that enhance the discourse of both concepts in contemporary child health care practice. Thus, the emerging dimensions of both concepts in this study were driven by the socio-cultural orientations of the studied participants, which are consistent with the literature.

Childcare from the Ghanaian and African perspective is a communal duty among parents, families and communities (Falola, 2000; Falola and Salm, 2002; Imoh, 2012; de Beer and Brysiewicz, 2017). The care customs, although similar in many ways, equally differs in several ways across cultures and families as a result of geographical locations, cultural values and norms, religious beliefs and practices. For example, in most African communities, there are culturally predetermined gender-specific roles in childcare. However, parenting, regarding what children are allowed to do and what parents do for children all vary within the different sub-cultures and families (Olowodunoye and Titus, 2011). This Findings from this study demonstrated that when a child is hospitalised, families expect that the culture of caring together with health professionals will happen collaboratively

and this influenced the perceptions and practice of parental presence and family involvement in this study.

## 7 Chapter 7: Discussion

### 7.1 Introduction

This chapter presents the discussion of the research findings. In this qualitative research, a grounded theory approach was adopted. There is abundant literature on Family Centred Care (FCC), but there is limited knowledge on this concept from the Ghanaian context. Hence, this exploration of perceptions of FCC is the first of its kind in Ghana. As such, an extensive review of the literature at the beginning of the research was not a major requirement (Glaser, 1978; Birks and Mills, 2011). However, according to proponents of the constructivist grounded theory, research must tailor the final version of the literature review to fit the specific purpose and argument of the research reports (Charmaz, 2014).

This chapter will explore the connections and relationships of the model developed in this study to the broader literature. It provides a broad discussion through a review of existing documents, policies and regulations regarding the key findings of related research in the field. The findings of this research revealed phenomena that are consistent with the existing body of knowledge, as well as key findings, which are unique to the Ghanaian context.



This chapter is organised into three major sections. The first section discusses the exploration of *parental presence* and *family involvement* in the context of existing literature using the main features of the model as the focus. The second section sets the findings in the broader context of religious, legal and medical practices in Ghana. The final section involves an integrated discussion of the key findings in a conceptual framework.

## 7.2 Parental presence

The research findings, as illustrated in figure 7.1 mainly demonstrated that parental presence was influenced by the emotions, care roles parents perceived and performed, and the ways they needed to negotiate the medical system.

Figure 7.1 Parents' perceptions and experiences of the care for children in hospital



Parental presence characterised by the perceived sub-categories as shown in Fig 8.2 is reflected in the FCC literature (Ebrahim, Singh and Parshuram, 2013; Coyne et al., 2011; Corlett and Twycross, 2006; Kristensson-Hallstrom, 2000; Coyne, 2015; Callery and Luker, 1996; Byczkowski et al., 2016; Sousa et al., 2013; Lee, 2004). In this study, emotional well-being of the child and the parents' emotional management emerged as one of the substantial reasons for parental presence in the hospital. This perception is reported in the literature (Ames, Rennick and Baillargeon, 2011; Callery and Luker, 1996; Punjani, 2014).

Historically, parental separation and its associated negative consequences on children, such as emotional disturbances, are widely reported among children separated as a result of wars and hospitalisation (Jolley, 2007; Bradley, 2001b;

Brandon et al., 2009; Alsop-Shields and Mohay, 2001b; Barnes, 2009). This phenomenon observed in hospitalised children was mostly attributed to the traditional medical model of health delivery which did not recognise parental presence as an essential component of healthcare (Jolley and Shields, 2009). Generally, signs of emotional changes in children during hospitalisation has prompted calls for greater parental presence in hospitals. The findings from this study also confirmed that the hospital environment (consisting of staff as strangers to the sick child) and equipment are sources of stress and anxiety to children. This situation required that parents should be present with their child in the hospital (Punjani, 2014) to allay any fears and anxieties the child may have.

The mere presence of parents in hospital can be comforting to the child (Pongjaturawit et al., 2006; Callery and Luker, 1996; Punjani, 2014). The meaning of parents' presence perceived in this study is sitting by the bedside, talking to the child, holding the child's hand and praying for them. The parents also observe the child to timely notify staff in the event a change in their condition. It is also perceived that parents' presence enables children to verbalise their fears, pains and needs. Contrasting this view, Piira et al. (2005) reported that during invasive or painful procedures, some children show unwarranted behavioural attitudes such as crying uncontrollably due to the presence of their parents. However, Punjani (2014), asserts that children becoming more anxious in the presence of their parents buttresses the need for parental presence to enable children to verbalise their feelings of discomfort. The goal of parental presence in this

perspective, therefore, is to minimise the situation where children have to endure suffering and pain in silence (Punjani, 2014).

The contemporary focus of parental presence has been in the domain of painful, invasive medical procedures. For example, parental presence has been recommended and promoted during invasive procedures and resuscitation at emergency units (Boudreaux, Francis and Loyacano, 2002; Moreland, 2005; Parkman, Henderson and Knapp, 2006; Egging et al., 2011; Pruitt et al., 2008); in the intensive care units (Ebrahim, Singh and Parshuram, 2013; Wigert, Hellström and Berg, 2008; Wigert, Berg and Hellström, 2010); during bedside rounds (Grzyb et al., 2014) and in operating theatres (Kisby, 2016; Shields, 2007). It is worth noting that the African culture teaches children to accept customs without questioning or challenging their rationale and essence (Salm and Falola, 2002; Mahat and Phiri, 1991). This cultural practice of absolute acceptance of customs reflects in every aspect of their social lives. Which, therefore, suggests that children in hospitals may be under duress from both parents and staff to suppress their pain and discomfort. This culture of silence may inversely negate the idea of parental presence, which is intended to enable children to verbalise pain ((Punjani, 2014). Alternatively, if FCC is understood in a cultural context, perhaps health professionals may use parental presence to limit the child's expression of pain.

Parents' sense of reassurance about the non-life threatening condition of the child, coupled with the idea that the child is receiving the best form of care from

professionals, was identified as a key to the parents' emotional well-being. In this context, the perceptions that children may not receive adequate care and professional supervision echo the findings of Callery and Luker (1996). Persistent acute medical staff shortage is a common phenomenon in Ghana (Norman et al., 2012; Atinga et al., 2015). Hence, hospitals are always overcrowded with patients for which nurses and doctors are perceived to be regularly busy with life-saving tasks. Hence the parents indications that their children may not have adequate nursing supervision and care and therefore the need for their presence in the hospital was crucial.

Parents who are given the opportunity to care for their child in the hospital, even with minimal participation in medical decision-making process, experience greater emotional wellbeing and satisfaction with the care system (Ames, Rennick and Baillargeon, 2011). In this study, the perceptions of both parents and professionals about parental care tasks in the hospital were in greater sense no different from what is reported in the literature (Pongjaturawit et al., 2006; Stuart and Melling, 2014; Callery and Luker, 1996). However, parental care in the hospital in this study was gender biased, with the perception of parental care in hospital being the mothers responsibility (section 6.4.4) and this is not foreign in the Ghanaian context (Pollard, 2006), and neither exclusive to Ghana (Daneman, Macaluso and Guzzetta, 2003; Jorosi-Tshiamo, Mogobe and Mokotedi, 2013). For example, Nielsen (2006) in her editorial for the Kai Tiaki New Zealand Nurses Journal asserts that mothers generally represent the family in the hospital. Although she acknowledges that societal changes promote fathers' increased

participation in childcare, the daily care of children remains a woman's responsibility.

The practice of parental presence is regarded as a key element of FCC, and central to preserving the family unit in childcare. It involves parents being incorporated into care as equal partners where no limits are placed on parental visitation (Butler, Copnell and Willetts, 2014). In doing so, parents feel in control of their child's care and this enables them to negotiate roles (Pongjaturawit et al., 2006). In this research, almost all participants desired parental presence although parents were not perceived as equal partners. The cultural background of parents and the manner of medical practices influenced parents perceptions and experiences of parental presence. This is discussed in the following sections.

#### *7.2.1 Managing emotions as the basis for parental presence*

Parents' coping strategies and stress management techniques during a child's hospitalisation are one of the primary reasons for parental presence. My findings demonstrated that the effect of the child's hospitalisation on parents and families, and the responsibility of parents to ensure the emotional well-being of their children was one of the main reasons they stayed in the hospital. Similar findings exist in the literature (Coyne, 2015; Byczkowski et al., 2016; Blesch and Fisher, 1996; Matziou, Chrysostomou and Perdikaris, 2013). For example, Byczkowski et al. (2016) in a focus group study identified emotional support as the first of eight dimensions of family centred care. Parent participants in their study described feelings of anxiety and fear associated with the diagnosis and treatments of their children. Devitt (2004), in an ethnographic study also viewed

the concept of parenting a child in the hospital as a distinct cultural group. His findings revealed under the theme of *emotional upheaval* expounded the notion that an emotional disturbance was a constant and significant factor among parents who stayed in the hospital to care for their children.

The underlying causes of parental emotions in hospital varied in the literature. Parental anxiety, fear, worry, sadness and distress are perhaps unsurprisingly widely reported (Foster et al., 2017; Noyes, 1999; Hallström, Runeson and Elander, 2002; Konuk Şener and Karaca, 2017). The parents' initial thoughts and concerns about the child's involvement in RTA relate to the prognosis, needs for hospitalisation and its related consequences. Naturally, the thoughts about whether the severely injured child will survive the injuries or die are not out of place. In a typical acute setting, children look very ill, which is often the case of the RTA injuries in hospitals. Thus, the health professionals approach to care in such context often prioritises the health of the child over other care issues such as interactions and relationship building. Therefore, interactions between professionals and parents in this regard are expected to be brief, factual, technologically focused (Espezel and Canam, 2003), which substantiates parents emotional expressions that characterised this phase of care.

Evidence suggests that maximising information provision is a significant process to manage parental stress, anxieties and emotions (Ames, Rennick and Baillargeon, 2011; Colville et al., 2009). Information on the child's status, understanding the rationale for the choice of treatment and knowing what to

expect next is vital to parents (Ames, Rennick and Baillargeon, 2011). It is also suggested that giving parents the opportunity to verbalise their fears, and anxieties, also ask questions about pertinent issues is very important (Colville et al., 2009). However, it is evident that in a busy hospital environment, which becomes stressful to families, not all parents can express themselves to others (Hallström, Runeson and Elander, 2002; Colville et al., 2009),

There is also a cultural phenomenon within the African context, which affects parents' communications and their ability to verbalise fear and anxiety. According to Miola (2015), people from non-western cultures are less likely to have open communications with health professionals. This argument which holds in the African context is rooted in the cultural upbringing whereby open communication is suppressed during childhood. Unlike in the western cultures where children are allowed to express their opinions and feelings more freely and even insist on their rights, the African child has no voice in the society due to their positions at the lower end of the social hierarchy (Salm and Falola, 2002; Mahat and Phiri, 1991; Asander et al., 2013). This cultural nurturing perpetuates in adulthood, which primarily reflects as moral responsibilities towards others in the form of respect to elders and authorities and limited disclosure (Miola, 2015). This, therefore, suggests that most parents in hospitals are less likely to express their anxieties and emotion openly. It also follows that they may be unable to seek information on their child's treatment and progress.



The effective management of parental anxieties and emotions from a professional perspective requires a culturally appropriate, evidence-based practice guideline on parental presence. A significant number of researchers and international organisations have proposed practice guidelines to facilitate parental presence and involvement (Coleman and Smith, 2010; Curley et al., 2012; Guzzetta, Clark and Wright, 2006). Elements of such guidelines may include the provision of parent facilitator resources, which aims to meet parents information needs, provide emotional support to parents and maintain the integrity of the health institutions (Curley et al., 2012). Irrespective of the clinical setting, parent facilitator practice is believed to ensure that a member of staff is assigned to parents with the ultimate goal of working towards consistency between the services and service providers (Dyke et al., 2006). Consistent information to parents will empower families (Ygge and Arnetz, 2004; Newton, 2000; Newton, 2000), as well as ease any stress that arises from ignorance and uncertainty (Hughes, 2007). In line with similar findings among mothers of sick children in the intensive care unit, in South Africa, Roets, Rowe-Rowe and Nel (2012) recommended a family empowerment program, COPE (Creating Opportunities for Parent Empowerment; originally by Melnyk et al. (2004)) practice in hospitals to help parents in the management of information and stress related issues. The aim of COPE is to enhance parents' knowledge and understanding of the child's physical and emotional responses to illness during and after hospitalisation, and to manage parents' involvements in this regard (Melnyk, Feinstein and Fairbanks, 2006).

Evidence suggests that parents were also doubtful about the quality of care to children in hospitals. Underlying this doubt was the noticeable large numbers of patients on admission and the evidence of perennial staff shortage associated with hospitals in Ghana (Norman et al., 2012). Typically, patients and families visiting any acute care settings will have high expectations to receive a high quality of care. Good interpersonal relationships, prompt personalised care, physical environment, and evidence of professionals' technical knowhow are some of the essential elements of quality services concerning patients attending acute care settings in Ghana (Atinga et al., 2015). Therefore, if parents are allowed to stay in hospitals as suggested by the findings of this study, it will ensure that additional care is given to the injured child, which will mitigate some of the issues of concerns to patients and families (Coyne et al., 2011; Kristensson-Hallstrom, 2000; Callery and Luker, 1996; Kristensson-Hallstrom and Elander, 1997).

Although the focus of my research was on hospital care experience, almost all the parents persistently recounted their pre-hospital experiences, which mirror similar findings by Colville et al. (2009). For example, the parents who accompanied their children to the hospital described overwhelming anxieties prior to the hospitalisation. This was due to the lack of medical care during transportation to the hospital. In Ghana, it is public knowledge that the national ambulance service is under-resourced and ineffective. Therefore, most of the children arrive at the hospital by public transport, which runs on irregular and ad hoc basis with poor network systems (Nee-Kofi Mould-Millman, Rominski and

Oteng, 2014; Atinga et al., 2015). Concerning injuries in Ghana, Atinga et al. (2015) identified that RTA, which was the second leading emergency condition among patients at four different emergency units all arrived in the hospital by non-ambulance means just as observed in this study.

Colville et al. (2009) identified that parents viewed the pre and post-hospital care of children's emergencies as the most challenging point of their emotions. This was mostly true in the report of the current study. Some parents recounted experiencing relapse medical conditions on the journey to the hospital and expressed fears related to the impacts of the injury on the future functioning of their child. Although this may be true, the phase of pre and post-hospital care is not the focus of this research. Another research in this milieu may be worth considering in future studies

### *7.2.2 Negotiating the care system*

According to Callery and Smith (1991), negotiation is the process applied by nurses to agree on acceptable parental behaviours with parents. It also involves the process of shared decision-making about the child's care, as well as deciding on which family member provides childcare in the hospital (Corlett and Twycross, 2006). Evidence suggests a lack of real negotiation of care in several contexts (Coyne et al., 2011; Corlett and Twycross, 2006; Young et al., 2006b; Young et al., 2006b). For example, Young et al. (2006b) conducted a study among parents in Australia to understand their perspectives on the role of negotiation of care for hospitalised children. The majority of the parents in their study were unsure of the

care roles expected of them. Although parents commended the idea of negotiation, they reported no evidence of negotiation between them and clinicians.

The findings from this study indicated a different twist to the negotiation processes reported by Callery and Smith (1991) and Corlett and Twycross (2006). In this study, parents were involved in negotiating professional barriers to gain acceptance in the children's ward. As evident from the professional data, nurses perceived that parents' care roles must be assigned, controlled and supervised. However, the reality on the ground identified that there are complex barriers that emanate from the managerial procedures within the hospital environment. This is further compounded by the preconceived ideologies about who the health professional is from the perspectives of the Ghanaian public. It, therefore, follows that parents have to negotiate at two fronts – institutional arrangements, as well as the individual professionals, to achieve parental presence.

The healthcare service delivery system within the settings of this study is based on hierarchical arrangements, which is one of the managerial principles of a teaching hospital (Akukwe, 2008). This follows that there are officially established powers and authorities at the various operational levels. It is the norm in Ghana that the local community is represented at the highest board level; such cannot be said of the care delivery levels on the wards. The health professionals mostly dominate care delivery with less emphasis on patient and family inclusion. To put

this in perspective, Gyasi et al. (2016b) identified that, the lack of patient-centred care in the healthcare system generally in Ghana forms one of the reasons for alternative therapy use. According to these authors, hospitals in Ghana are perceived as a “distant health care system” (Gyasi et al., 2016b) and this reduces the interest and trust of the public in the hospital system.

Professionally dominated healthcare systems, which is characterised, by less patient and family involvement, also stem from a perception of social class segregation within the Ghanaian socio-cultural context. Here, there is a commonly held view that a gap exists between educated elite professionals and predominantly uneducated healthcare seekers (Andersen, 2004; Donkor and Andrews, 2011). This argument dates back to the 1970s when Masemann (1974) revealed that the Ghanaian educational system is primarily programmed to socialise students into western modern culture and values with less emphasis on the traditional Ghanaian values. Successively, in Ghana, formal education has become a form of social class identity, which divides people into educated elites and uncivilised villagers (Andersen, 2004). High academic achievement is associated with respect and authority. Additionally, academic qualification through formal education is directly linked to public salaried job acquisition, which is considered as a primary route to wealth and influence (Andersen, 2004). In this light, health professionals, irrespective of their cultural background are perceived as educated elites, a perception which legitimises their power and authority within healthcare institutions (Moyer et al., 2014). Consequently, patients and families

are required to subject to these professional authorities in hospitals and comply with their instructions (Andersen, 2004).

Returning to the main point of negotiation, the social status of the patient and family is deemed as an essential factor in the negotiation process due to beliefs that health professionals give differential treatments based on their judgement of the individuals' social class status (Andersen, 2004; Atinga, Bawole and Nang-Beifubah, 2016). The alleged differential treatment in healthcare is perceived to favour the educated elite, the wealthy and public figures, and the family and friends of health professionals. This follows the argument that "*a person of low social status cannot lay claim to favours, respect or attention from a person of higher status, unless the two are related or in other ways obliged towards each other*" (Andersen, 2004 pg.2006). Consequently, patients who are perceived as under-educated and poor are alleged to experience delays in care, given less information treated with impatience and disrespect (Andersen, 2004).

Given the complex politics and power dynamics, which results from the hierarchical arrangements and social status within the hospital environment, parents often engage in negotiations of relative status, which is perceived to produce a particular allocation of power between them and the professionals (Atinga et al., 2014). These negotiating strategies within the medical system in this study took the form of parents utilising their social connections to influence professionals, a phenomenon very common in the Ghanaian context (Atinga, Bawole and Nang-Beifubah, 2016). Often, parents contacted family relations,

friends or powerful influential public figures whose influence secured them professionals' approval to stay in the hospital with their child. This approach to negotiation reflects the relationship between *influence* and *power* in negotiation often used in working with children and young people (Charles-Edwards, 2003). Handy (1993) cited by Charles-Edwards (2003) differentiated between influence, power and authority. "*Influence is the process whereby 'A' seeks to modify the attitude of or the behaviour of 'B,' and power is that which enables him to do it. Authority is used when the power is legitimate and has some recognised official backing*" (Charles-Edwards, 2003 pg.38). Handy (1993) suggested a number of ways power can influence and be influenced overtly and covertly. Relating to this study, parents reported that professionals overtly applied "*rules and procedures*" to control parental presence and this detailed under section 6.6.2.

Charles-Edwards (2003) asserts that the method of exchange in processes such as negotiation, bargaining, cajoling or bribing may be used to influence such powers. Thus, parents' negotiation strategies in this study primarily reflected these exchange techniques. After parents gained access to their children, exchange of favours ensued between nursing staff and parents. This took the form of parents having to prove their worth to the ward nurses by doing housekeeping chores such as participation in sanitation and hygiene maintenance of the children units. This occurred in addition to the essential childcare and the running of errands for ward nurses. Similar to the findings of Wilbourn et al. (2000) cited by Mountain (2010) observes that this is a deliberate and natural strategy that mothers employ to develop productive relationships with professionals to feel confident in approaching them for support and advice.

### *7.2.3 Parental care roles*

Parents desire an active role in hospital and being involved in childcare is reported in a good deal of the literature (Pongjaturawit et al., 2006; Stuart and Melling, 2014; Ames, Rennick and Baillargeon, 2011; Kristensson-Hallstrom, 2000; Callery and Luker, 1996). Callery and Luker (1996) and Hewitt (2002) reported from separate studies that, next to emotional well-being, parents believed that the care they provided was necessary to supplement nursing care.

The parents' belief that their presence and services were required in the hospital was not just mere perceptions, but the real situation on the ground. The Ministry of Health, Ghana (2007) identified that acute staff shortage across all the health professions forms a major contributing factor to the nation's non-achievement of reliable and quality healthcare targets. Three years after the MOH publication, Norman et al. (2012) reported on persistent, inadequate human resources at all the regional hospitals in Ghana. According to them, acute staff shortages emerged as one of the five major factors, which contribute to the unprepared states of Ghanaian hospitals in their efforts to manage medical emergencies. Thus, the parents' perception that there was a shortage of qualified nursing staff to care for their child in this study is borne out by the available data.

Despite the apparent shortage of personnel on the wards, parents' desire to assist in their child's care did not guarantee an active parental involvement in care. Parental presence was characterised by limited involvement initially, and



eventually active participation in care depending on how well parents negotiated the care system. A number of studies (Kristensson-Hallstrom, 2000; Lam, Chang and Morrissey, 2006) have reported that parental involvement in their child's care in hospital progressed from passive presence to basic care, then to increase participation in some clinical intervention. This was due to the critical nature of the child's initial condition, which required expert life-saving skills at the initial stage of admission (Fegran, Fagermoen and Helseth, 2008). As such, the brief professional-parent contact which characterised this phase was perceived by parents as inhospitable.

Irrespective of the critical nature of this phase of care for the injured child in the hospital, studies conducted in the western countries such as United States, United Kingdom and Canada suggest that parents increasingly have expressed their interests to be part of that phase of care (Rattrie, 2000; Hanson and Strawser, 1992; Twedell, 2008). These studies support the arguments that the benefits of parental presence supersede the perceived reasons for parental exclusion during acute resuscitation phase of care. Consequently, some authors have recommended guidelines for parental presence and family support during the acute phase of childcare (Twedell, 2008; Egging et al., 2011; Ebrahim, Singh and Parshuram, 2013).

Furthermore, parents required time to assess and adapt to the caring culture in the hospital. Many parents negotiated this challenge mainly by learning from other parents. Also, and most importantly, it was necessary to get nurses'

permission and approval to be involved in the childcare. This is due to the largely paternalistic characteristic nature of the hospital environment, which follows the public perceptions of hospitals being a special place for highly knowledgeable people like doctors and nurses (Andersen, 2004; Abedini et al., 2015; Gyasi et al., 2016a). Consequently, parents in the hospital play subservient roles to the professionals. This echoes the findings of Shields and Nixon (2004) that, in low-to-middle income countries, doctors and nurses, classified among the highly elite class in the society give orders and the expectation was that parents would be obedient and conform to the professional orders.

#### *7.2.4 Socio-cultural influences underlying gender specific care roles*

Mountain (2010) shared concerns about several assumptions often made about family dynamics, which influences thoughts, processes, and sometimes policies, which reflect in practice. Parents are often recognised as the most significant relative for the positive influence for child's growth and development. In addition, a parent symbolises that which is portrayed in heterosexual marriages. Thus, parenting is also viewed as displaying the natural behaviours and skills necessary for the successful socialisation and development of children (Mountain, 2010). Notwithstanding these assumptions, McCollum, Ree and Chen (2000) admitted that the characteristics of parenting and parent-child relationships are often derived from culturally limited samples, resulting in a conventional construction of the family (Mountain, 2010). Furthermore, it is inappropriate to assume that

what parenting and therefore parental roles are in other cultural contexts will fit all other contexts including Africa (Söderbäck and Christensson, 2008). Unsurprisingly, the findings from this study largely reflect the influence of the social perspectives of the African construct of the family, which characteristically extends beyond the nuclear, and yet, with culturally predetermined gender specific roles.

The socio-cultural construct of family and the value placed on children raises societal expectations for parents, in that, motherhood especially is viewed as a sacrificial duty (Akujobi, 2011). Parent participants in this study perceived parenting in the African context as complex and challenging which is rooted in the significant role of motherhood in African society. This perception ensued as parents expressed feelings of blame and guilt for having contributed to their children's predisposition to the RTA. Commonly in the Ghanaian tradition, children are comfortably allowed to explore their environment with minimal supervision, without much thought about the dangers of modern life such as accidents, kidnappings and abductions, which are emerging crime in Ghana (Lawrance, 2010). Furthermore, most people including children often play games in any open space usually on neighbourhood streets, open grounds, residential areas, and even car parks due to the lack of smaller and more accessible public play facilities. However, there is evidence of high risks associated with children playing as well as helping in a family business without adult supervision (Abantanga and Mock, 1998; Laird, 2011b; Teye, 2013). In relation to this study, family businesses, such as hawking on the street, which is common to the

average household in Ghana, exposes children to the risk of RTAs. Consequently, when a child is involved in a preventable catastrophe like accidental injury such as RTA, the feelings of blame and guilt among parents perceived in this study is inescapable (Foster et al., 2017). Therefore, it was not surprising that parents perceived a sense of social pressure on them to demonstrate their innocence through commitment to give care to their sick child in hospital, even under difficult conditions. The rationale was to avoid public criticism.

Generally, in all cultures, parenting is seldom shared equally (Mountain, 2010) and such is observed in the African context. Traditionally, parents in the immediate nuclear families are the primary carers for children, as reflected in parental presence as well as family involvement in this study. Next to the biological parents is supplementary childcare, which follows the cultural practice associated with community dwellings and kinship systems common in the Ghanaian context. The kinship system upholds additional caring support from extended family relatives to children in a fosterage care system (Imoh, 2012). This ensures that other members of the extended family are also eligible to participate in the primary care for the child. Therefore, the presence of the two grandmothers and an auntie in the hospital as primary carers reported in this study is unsurprising and not foreign within the context of this study.

It is also perceived that childcare in the African context is naturally a female responsibility based on the social condition, engagement and participation of

mostly mothers (Grantham-McGregor et al., 2007). This follows the upbringing of the girl child purposively to bear children and become excellent in doing domestic work. Therefore, the maternal representation of the family in hospitals reported in this study traces to the gender specific roles rooted in the African culture (Salm and Falola, 2002; Falola, 2000; Jardien-Baboo et al., 2016; Imoh, 2012; Scott et al., 2014). Thus, the African societies including Ghana traditionally assign childcare roles and responsibilities to women (Nukunya, 2003; Salm and Falola, 2002).

Pollard (2006) revealed that the maintenance of physical contact with the child is a comforting maternal role within the Ghanaian context. Mothers achieve this by fastening the distressed child to their backs with a piece of cloth as a way to make the child feel secure and comforted. This cultural practice occurs for a typical child until about the age of five. In the case of the sick child, there is often no age limit to cease fastening children to the mothers' back. It is often a technique of mothers to comfort the upsetting child. Sometimes, it is also used purposively to aid the mobility of the sick child. The physical closeness which characterises the relationship between children and their mothers further account for mother's unique roles in recognising illness in children; an important role of mothers in Ghana (Pollard, 2006). This unique caring method of motherhood is also perceived as helpful for the primary care and supervision role, valuable to augment nursing care that Callery and Luker (1996) identified in their study. On the contrary, such unique, intimate motherly care was not supported by the findings of this study due to the complex nature of injuries children sustained and

the care interventions required. For example, children in tractions, POPs and splinted body parts were mostly restricted to their beds and parents were advised to avoid lifting the children. Furthermore, there was no such evidence that parents would be allowed to carry their children around in the hospital due to the perceived mistrust of parents.

Compared to their girl counterpart, the African boy is encouraged to participate more in academic pursuits and recreational activities. The boys are taught to move more closely with their fathers as they are socialised to command power and authority in the community. At a very early age, they are engaged in the family's economic activities as a way of training them for their future role as the main financial and economical source to the family (Nukunya, 2003; Salm and Falola, 2002). Additionally, evidence suggests that among low-income and working-class fathers, it is stressful for most fathers to achieve the contemporary norms of fatherhood, which emphasise the dual demand of breadwinning for the entire family as well as participating in daily childcare (Nomaguchi and Johnson, 2016).

Consequently, fathers whilst not excluded in care are perceived as supportive of mothers mainly through financial provision. Fathers' support may be few hours with mother and child in the hospital and as well supporting the other children at home (Roets, Rowe-Rowe and Nel, 2012; Hughes, 2007; Roach, 1992; Pryzby, 2005; Hallgrimsdottir, 2004). It is recognised that fathers do play active roles in childcare in some other context such as in the United Kingdom (Highman and

Davies, 2013), Ireland (Hughes, 2007) and to some extent in Bangladesh (Murshid, 2016). However, within the context of sub-Saharan African, where cultural norms regarding domestic gender roles are changing at slow pace, health professionals are urged to be supportive of fathers' roles in the care of the sick child. For example, Söderbäck and Christensson (2008) recommend that fathers who avail themselves to spend the night with their children in the hospital should be allowed to do so as this will encourage and promote their overall active participation in the child's daily care. Currently, there seems to be limited evidence of nurse educators promoting the teaching of male involvement in childcare.

It is evident that the cultural perspective of the African family and functions is gradually changing to reflect the structure of European and North American society due to urbanisation and changes in the cultural values and economic challenges (Imoh, 2012). Effectively, marriage is no longer an essential primary goal. Furthermore, lone parenting and reconstructed families, either by choice or by resulting from divorce, is a phenomenon that is on the ascendancy. The background information on participants from this study mirror this societal shift in the traditional family structure (see Table 4.2). Therefore, professionals require a cross-cultural knowledge of parenting to comprehend fully, the complexity of the child and family-centred care in order to meet the needs of families and their sick children.

#### *7.2.5 Challenges encountered*

The findings identified several significant challenges to parental presence. These included visiting schedules, parents' exclusion in care, nurses' attitudes toward parents, and the quality of meals served to children, as well as the unsustainable cost of healthcare. Bradley (2001a) reported that restrictions on the constant parental presence in children's hospital were a common practice in Britain in the years of 1940s and 1950s. Similarly, Young (1992) revealed that until the 1960s, not all parents had equal rights to constant access to their sick child in Hospital for Sick Children, Toronto, Canada. Young (1992) reported that social class difference based on wealth and level of professionals' knowledge shaped attitudes towards families of hospitalised children between the years of 1875 and 1960. Both Bradley (2001a) and Young (1992) reported that during the years of parents' restrictions to the hospitalised child, many authors recorded detrimental effects of separation on children from both England and Canada, as well as other in western countries.

Research continues to record the adverse effects of parental separation on children and families, and parents themselves (Coyne et al., 2011; Callery and Luker, 1996; Kristensson-Hallstrom, 2000; Blesch and Fisher, 1996; Kristensson-Hallström, 1999). Blesch and Fisher (1996) studied the relationship between parental presence and anxiety of parents of children recovering at the post-anaesthesia care unit. The study results revealed a significant rise in the blood pressure and pulse rates of parents when separated from their children. Normal readings were recorded when parent were reunited with their children. Other studies have also demonstrated the positive effects of parental presence on



children in the hospital. Matziou, Chrysostomou and Perdikaris (2013) found that parental presence was associated with reduced vital signs, lesser pain expressions and reduce stress behaviours in children. The children's pain and stress levels were measured with the pain assessment scores and State-Trait Anxiety Inventory for Children. A significant difference was found between the scores of the group of children who had their parents present during the clinical procedure and those who were only distracted by a play toy. The study acknowledged its limitation, such as its inability to control other environmental variables that may be a source of distraction and as well influence the outcomes of the statistical scores. Nevertheless, the study concurred that although the use of distractions techniques in managing stress and pain in children may be useful, parental presence offered the best outcome.

The emotional needs of children separated from their birth parents and families have been explored elsewhere in Ghana. Bettmann, Mortensen and Akuoko (2015) explored the perceptions of emotional needs of children among orphanage caregivers. They reported that children living in orphanage care homes often expressed a desire for parental love and support. The inability to reunite the children to the traditional family life leads to the lack of physical contact of comfort and security the Ghanaian child derives from their parents. Long parental separation can leave the child with a lasting psychological effect, which could be detrimental to their future health (Jolley, 2007).

According to the legal provisions in Ghana, deliberately denying parents of care responsibilities to their child without a just cause could amount to violating their rights. The Children's Act 1998 (in Ghana) encourages the idea of children living together with their biological parents irrespective of their socio-economic situations. Key sections of the Act highlight the important roles of parents in creating a peaceful environment for the growth of the child. This suggests that denying children access to their parents and family with the excuse of giving medical interventions is unjust and not in the best interest of the child. It may also have legal implications as some parents could interpret it as a violation of the rights of the child and as well as the parents. Health professionals need to understand the legal implications of their engagements and interactions with families in relation to the care of children in hospitals in order to avoid the violation of parents' rights.

Jardien-Baboo et al. (2016) identified unprofessional staff attitudes as barriers to patient centred and FCC. They reported that nurses were rude during interaction with families. They recorded nurses choice of words as similar to those reported in my findings. For example, parents described staff communication with patients and family as "*harsh*" and "*rude*" (Jardien-Baboo et al., 2016). In Ghana, poor staff attitude is identified as a national menace to the delivery of quality healthcare. The National Health Policy (2007) stated that "*Users routinely complain of abusive and humiliating treatment by health providers*" pg.25. Furthermore, professionals-patient/parents relationships, which are influenced by social class status is likely to jeopardise professional standards and create ethical

and moral challenges on daily basis in health institutions (Donkor and Andrews, 2011). Obviously, the nurses' attitudes affected parental presence and participation negatively. The perceptions of fear of being embarrassed by nurses affected mothers' ability to negotiate care.

Poor living conditions such as sleeping conditions in hospitals reported in this study is in accordance with some existing literature (Lam, Chang and Morrissey, 2006; Rutledge, Donaldson and Pravikoff, 2000). Lam, Chang and Morrissey (2006), for example, reported that over half of parents' participants from four different hospitals in Hong Kong China commented on the ill-equipped hospital facilities for parents. Three specific facilities that were highlighted in several studies reviewed by Rutledge, Donaldson and Pravikoff (2000) include lack of sleeping arrangements, hygiene facilities and catering services. Similar to the findings of Lam, Chang and Morrissey (2006), there was lack of sleeping facilities for parents in my study. The parents slept on sofas and chairs by the child's cot/beside and complained of gluteal pains and numbness of the arm. There were no hygiene facilities such as bathrooms and toilets for the parents. The lack of resources to support families compromised parental safety, comfort and privacy, which substantiates parents' views of hospital care as a sacrificial task.

Furthermore, the high cost of healthcare, identified in this study, which is recognised in several other National Policies in Ghana (Ministry of Health, 2007; Offei, Bannerman and Kyeremeh, 2004) influenced the level of parents' involvement. Although it may seem like the parents stay in hospital may incur

additional cost, to some, it was financially less stressful as their transport fare was an added cost

### 7.3 Family involvement

This section presents the exploration of health professionals' perceptions and practice of *family involvement* in the care of hospitalised children. The concept of *family involvement* indicated in Figure 7.2 as a commonly held perception of FCC has been reported by many authors (Coyne et al., 2011; Young et al., 2006a; Jardien-Baboo et al., 2016; Coyne, 2015; Wong et al., 2015). Furthermore, the four sub-categories, which build up this category includes; *parental involvement*, *communication*, *setting boundaries* and *support to family involvement*, also exist in the literature.

Figure 7.2 Professionals' perceptions and practices of family involvement in the care of hospitalised children



The findings of this study suggest that family involvement is a relationship between the nurse, patient and family, whereby the nurse is in control of the interactions in this relationship. Family involvement in this sense reflects the overpowering influence of the health professionals in healthcare delivery, over the sick child, parents and the families' activities in the hospital (Casey, 1995; Hutchfield, 1999; Nethercott, 1993; Vasli et al., 2015).

Healthcare delivery approach in Ghana, which depicts a typical medical model approach, is a prominent feature in most children acute units. Medical decisions, as well as interpersonal relationships underpinned by the medical model, may

occur in an authoritarian way (Casey, 1995). The concept of FCC, perceived in this study as family involvement reflects the descriptions of FCC in its immature stage (Hutchfield, 1999; Nethercott, 1993). The health professionals in this study convincingly recognised the needs to involve families, especially mothers, in care provision. They were emphatic that family involvement benefits them, the professionals, children and the families. However, the manner of the application of the concept both conformed with and contrasted many reported studies (Follett, 2006; Goldfarb et al., 2010; Griffin, 2003; Meert, Clark and Eggly, 2013) as a result of culture-specific norms or what Hutchfield (1999) described as concept developed from a disorganised health care system.

#### *7.3.1 Parental involvement*

Parental involvement emerged as involving parents in a working patient-family-nurse relationship for the emotional stability of the child and maternal care to supplement the nurses' care. The perceived recognition of the child's family in care and collaborating with them in the interest of the child shows the professionals' sensitivity to the child's emotional needs and respect to family's wish to be present and participate in childcare. This perception is recognised as one of the principles of FCC (NCFPP, 2017), which is grounded in respect and dignity (NCFPP, 2017; PFCC, 2017). Respect and dignity in parent and family involvement in a collaborative way can be viewed from three dimensions; "*respect for the family as a constant in the child's life, respect to family's knowledge of their child and respect to family diversity life*" (Hutchfield, 1999 pg1185.).

The principle of respect and dignity for parents and families in the concept of family involvement recognises the family as constant in the child's life (Hutchfield, 1999). The professionals in this study unanimously alluded to the notion of the family as a constant and understood that without parents, children become emotionally insecure in the hospital. Professionals demonstrated the awareness that the hospital environment and clinical procedures had devastating effects on the emotional well-being of the sick child (Ygge, 2007; Bettmann, Mortensen and Akuoko, 2015). Thus, involving parents can mitigate some of the negative emotional effects by helping the child to feel secure, comfortable, less frightened and free from worries (Coyne, 2015).

The findings from this study perceived parents as valuable information sources for the care and treatment of the sick child, and Hutchfield (1999) reported this with respect to the family for the knowledge of the child who has grown beyond infancy. Children are born into families, and parents form part of their immediate social environment as carers and important players in their social world. Although this study did not view parents as experts due to the paternalistic nature of the clinical environment, parents' information contribution to assist diagnosis, treatment and care was valued.

Family involvement also recognises the respect to diversities of family life (Hutchfield, 1999). However, in this study, professionals showed bias by their preferences of mothers over fathers. The professionals in this study admitted that the gender specific roles in the Ghanaian socio-cultural context, which perceive

childcare roles as a maternal duty, influenced their decisions. This perception may hold largely for the most indigenous Ghanaians. However, it behoves professionals to be proactive and receptive to persons (locals and other national) who may differ by their family orientations. Beyond Ghana, a similar perception that childcare is a maternal responsibility and that the parental/family care role in the hospital should mainly be mothers' responsibility has been widely reported (Mikkelsen and Frederiksen, 2011; Nielsen, 2006; Murshid, 2016; Söderbäck and Christensson, 2008).

Despite the extensive recognition given to mothers as the day-to-to caregivers in the hospital, the role of fathers cannot be under-estimated. Professionals acknowledged the role of fathers as support to mothers and perhaps maternal substitutes in circumstances that could not permit the mothers presence in the hospital. Globally, the diversities in family practice have emerged in new definitions of which the family can be viewed as:

*“Big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents” (NCFPP, 2017).*

According to the NCFPP (2017), families are dynamic, and a culture unto themselves with different values and unique ways of realising their dreams. Besides, the family is not a static entity; its structure and functions are subject to change over a period. This implies that in practice families are whatever the family says it is and trying to label different forms of family is an exercise in futility. This does have implications for FCC in terms of the nursing admissions interview and seeking data about family structure as part of FCC. Given this, perceiving care



as a sole responsibility of mothers as perceived in this study may not be in the best interest of some families.

The active participation of the extended family in the Ghanaian culture should not be underestimated. Many authors have reported the vital contributions of external families in the wellbeing of the child (Salm and Falola, 2002; Falola, 2000; Imoh, 2012). For example, Imoh (2012) revealed the enormous socioeconomic benefits of kinship fosterage practice in Ghana where other extended family folks assisted in monetary and different ways of parenting and raising children. It therefore, suggests that health professionals in Ghana need to reconsider their bias toward mothers and adopt a more open attitude towards any member of the family who by their family's choice may be available to support the child in the hospital.

Elsewhere, family involvement recognises the contribution and participation of the entire family such as parents, siblings, grandparents and other relatives (Coyne et al., 2011; Nethercott, 1993; Söderbäck and Christensson, 2008). Siblings' visits to the injured child in hospitals must be encouraged, as such practices will promote stress management among families of the hospitalised child (Coyne et al., 2011; Coyne, 2008). The supportive roles of older siblings in the care of younger children in the home setting in Ghana have been well documented (Salm and Falola, 2002; Falola, 2000; Imoh, 2012; Scott et al., 2014; Nukunya, 2003). However, it appears that a child visitor in the hospital is a forbidden practice in the Ghanaian context as evidenced in this study. This decision on the part of the health professionals is rooted in the idea of infection

prevention and control. This infers that the understanding of hospital infections and the role of the family, as well its impact on family involvement requires some attention.

### *7.3.2 Communication*

In this study, communication in family involvement emerged as exchange of information between professionals and parents through the process of informing, explaining, instructing and educating parents and these mirror those from other studies (Ygge, 2007; Casey, 1995; Coyne et al., 2011; Hutchfield, 1999; Young et al., 2006a). For example, the professionals perceived history taking as an essential component of communication that aids in medical diagnosis and treatment. In this sense, they understood the initial interactions with families to establish the history of presenting condition and previous medical records of the child and family history as setting the tone for family involvement. Butler, Copnell and Willetts (2014) reported similar perceptions and presented information sharing as a cornerstone to FCC, for which without it, families will be unable to participate in the decision-making process. Although this perception may apply to some extent, it is not always the case in RTA injuries in Ghana. This study reported that sometimes, strangers at the scene of the accident sent children to the hospital and treatment started before parents and families arrived in hospital. Therefore perceiving history taking processes as a stage to set off family involvement only hold in situations where families accompany the injured to the hospital. The professionals' approach to communication, which consisted mainly informing, explaining and instructing as perceived in this study reveals a one-way

communication, which is hardly satisfactory (Hallström, Runeson and Elander, 2002).

Previous authors have reported professionals' awareness of parents' information needs as perceived in this study (Ygge, 2007; Coyne et al., 2011; Hutchfield, 1999). Ideally, information provided to parents should form part of the supportive package embedded in care, or provided on demand. According to the professional code of ethics (Ghana Health Service, 2017), information to parents is expected to be open and straightforward, with the content unbiased, clear and precise. In addition, Coyne et al. (2011) recommend that professionals provide timely information to enable families to make the necessary informed decisions. The professionals in this study admitted that most families leave the hospital with their communication and information needs unmet. Typically, in Ghana, there is a common cultural belief that when people are informed about the actual state of their medical condition, which in most cases may be critical, their health may deteriorate drastically and in many cases, they may even die (Donkor and Andrews, 2011). Therefore, health professionals are often confronted with the ethical dilemma of how much information should be given to parents, which may result in limited information as perceived in this research.

Some of the health professionals attributed the unmet communication needs to the low educational background and literacy level of parents, for which they were less inclined to find alternative ways to communicate effectively with the parents. Ideally, parents' interests and motivations to know about their child's condition

inform the depth of professionals' information provision. Gold et al. (2013b) identified that mothers of infants admitted to hospitals in Ghana are unable to know the right questions to ask about their child's illness due to their low literacy levels. This research also revealed the potential of parents being intimidated because of the harsh responses sometimes the health professionals especially nurses give to them. As such, many patients and their families in the Ghanaian context place less value on communication despite the high value and a strong desire for patient-provider interactions and professional support (Roger Ayimbillah Atinga, Gordon Abekah-Nkrumah and Kwame Ameyaw Domfeh, 2011).

Health professionals in Ghana reportedly hold beliefs that when patients are ignorant about their diagnosis and treatment, they are obedient, submissive and cooperative with professional orders (Donkor and Andrews, 2011). O'Haire and Blackford (2005) identified that one of the unproductive way nurses cope with stressful environment is to label parents in a negative light (such as uneducated, uncooperative or difficult), and then provide them with minimal information. This, therefore, echoes the findings of Andersen (2004) that health professionals undermine the amount and quality of information to patients and families labelled as being of low social class status in Ghana. Hutchfield (1999) reported that communication in family involvement should occur in verbal and written form, which perhaps may be impossible to some extent in the Ghanaian context due to the low levels of illiteracy and multiple languages spoken. Jardien-Baboo et al. (2016) also identified optimal communication as verbal and non-verbal

interactions between nurses and patients, which help to foster patient and family involvement.

Patient education and providing instructions as described in this study occurred verbally. The health professionals often sounded sceptical about the mothers' ability to read considering their low levels of education. This finding, however, is not surprising since mothers were mostly the parents at the bedside of the sick children in the hospital. Women's educational attainment in Africa is still a growing phenomenon. Many females within populations have no formal education (Salm and Falola, 2002; Falola, 2000) and this is often interpreted as low level of intelligence. Vasli et al. (2015) identified that in a communication process where professionals underestimate the intelligence level of their patients result in the process of non-interactive communication. They believe that it only communicates professional's superiority, which shows disrespect and mistrust towards families.

Communication difficulties related to the language barrier, non-English speaking families, low literacy level and lack of understanding has been reported (Coyne et al., 2011; Taylor, Nicolle and Maguire, 2013). The communication challenges common among most mothers in this study can be traced to the suppression of the child's opinions during childhood. The ineffective communication skills common among both parents and professionals is a phenomenon that emanates from cultural training during childhood. Thus, unlike in the western world where both boys and girls have equal access to education, the African girl child's

education does not attract the same level of support as her male counterpart. Hence, in most African countries including Ghana, there is low formal education among women (Armar-Klemesu et al., 2000; Windborne, 2004; Babu, Gajanan and Sanyal, 2014; Ruel et al., 1999). For instance, Söderbäck and Christensson (2008) found that majority of the family caregivers who accompanied the sick child to the hospital had no formal education and some were school dropouts. This observation was attributed to the fact that nearly all the family caregivers were mothers, grandmothers and aunties.

A two-way communication is recognised and the most effective strategy for dissemination and assimilation of information (Hallström, Runeson and Elander, 2002). Ideally, a two-way communication involves an information exchange on the grounds of equal and mutual benefits, with recipient and provider responding to each other in turns (Hallström, Runeson and Elander, 2002). However, Mahat and Phiri (1991) demonstrated how the emphasis on obedience among children in Africa influences the lack of assertiveness in adult years. Women especially are unable to speak out and stand for their rights, due to the fear of being tagged arrogant and disobedient (Mahat and Phiri, 1991). The one-way communication practices, as found in this study, negatively affected parents' negotiations skills as well as interprofessional communication among staff. This suggests a formal communication system approach between parents and hospital staff, and among professionals themselves.

Ghana is culturally a multilingual society and this makes language a crucial factor in the communication process. Health professionals are educated in the formal language, English; however, they are expected to provide services to patients and families from a diverse ethnic background in the language that they will understand. As shown in Section 5:2, the educational backgrounds of all the parent participants were below high school certificate level. Furthermore, many of the women do not speak English and the primary language of the health professionals is English. Hence, the potential communication issues are self-evident. Consequently, the language barrier was a common feature in everyday care.

In this study, ineffective inter-professional communication also emerged as one of the avenues by which professionals provide conflicting information to parents. This often led to a breakdown in relationships between staff and parents. A collaborative and integrated healthcare service delivery through effective communication is an important area in child health (Smith, Swallow and Coyne, (2015) and even of greater importance to the achievement of quality assurance in Ghana (Offei, Bannerman and Kyeremeh, 2004). Both Smith, Swallow and Coyne (2015) and Offei, Bannerman and Kyeremeh (2004) recognised communication skill as one of the standard core skill and knowledge for every professional in the working team. However, many authors have reported interprofessional communication challenges, which emerged in this study. For example, Ygge, Lindholm and Arnetz (2006) identified in their research that nurses raised concerns about parents being given conflicting information on the

same issues. In a different study conducted in Ghana, Aberese-Ako et al. (2015) demonstrated conflicts among professionals due to gaps in communication and limited inter-professional interactions. They found that organisational work arrangements and the practice of the various health professions was uncoordinated and lack inter-professional collaboration.

Elsewhere in Ghana, Inter-professional communication is perceived as a good and successful information sharing strategy among the key stakeholders in human resource management of the identified well-performing hospitals (Marchal, Dedzo and Kegels, 2010). The key features of good institutional communication included formal communication channels at all levels, regular unit and wards meetings, general quarterly meetings with all staffs (Durbars) and heads of units meetings with management. Ygge (2007) asserts that professionals have the duty to discuss what information is vital for parents. This will ensure that the same information meant for parents will be presented in the same way, and yet with presentation style and frequency tailored to cater for the needs of differences between families (Goldfarb et al., 2010). This suggests that the information needs of patients and family should be tabled for discussions at regular ward and unit meetings (Marchal, Dedzo and Kegels, 2010).

### *7.3.3 Support to parents and parental involvement*

Professional support for parental involvement emerged as advocacy for the formal establishment of family involvement backed by the policy statement. Most



of the nurses and medical doctors shared beliefs about the important elements for the effective implementation of family involvement. These were Institution and organisational support towards policy statement, staff training, infrastructure for parents comfort, and financial support to parents. Similar to this study, Coyne et al. (2011) and Alabdulaziz, Moss and Copnell (2017) in different studies from different sociocultural contexts identified lack of managerial and organisational support as a hindrance to the active practice of family involvement and implementation of FCC.

Coleman, Smith and Bradshaw (2007) recommended that institutions adopt and operate from the same philosophical framework for purposes of consistency in the practice of care that families will receive from different professionals. It is important that health professionals share same beliefs and understanding regarding their *modus operandi* for this consistency to occur in practice. Gonzales, Gangluff, and Eaton (2004) assert that institutions should encourage interprofessional practice to promote FCC. It is perceived that inter-professional practice is an approach that will enable children and families to benefit from interactions with professionals. This will mitigate the current frustrations among some professionals who identified the lack of support from colleagues due to their lack of skills and knowledge on the benefits of family involvement.

It is important that policy direct the practice of FCC to motivate staff attitudinal change (Moretz and Abraham, 2012). There was enough evidence from this study that professionals were aware of the need for hospital policy and guidelines

to promote the effective practice of the FCC in their work environment. However, most of them depend on the hospital leadership to develop such practice document as they share the perceptions that the administrative management has the upper hand towards the implementation of practice guidelines. To some extent, this may be possible with the input from clinicians and the senior leadership team. However, Kelly (2007) also suggested a process of developing a model of FCC, which involves working with nurses and families through the various stages of planning the process, developing and implementation of that change desired. This process ensures engagement and involvement of all stakeholders in a successful implementation of a change in practice, which demonstrates an evidence-based change. It also replaces the element of “having to work on people” to an approach of working with people (Kelly, 2007). This will also achieve a sense of ownership, empowerment and consistency among professionals and parents.

Support among parents was perceived in a negative way. Nurses especially identified parent-to-parent support as an avenue for gossip among parents. Nurses believed their activities on the ward were always the topic for parents' discussions. This communicated a sense of mistrust between nurses and parents. However, Alabdulaziz, Moss and Copnell (2017) identified that parent-to-parent support is important and promotes parental involvement. The practice of open and transparent communication should improve trust between the professionals and families in the caring relationship.

Staff support to individual families and parents were identified and perceived as one factor to improve family involvement. Professionals were aware of the many challenges facing parents in the course of their child's illness. They also reported the substantial financial cost that parents incur for drugs, food and transport back and forth to the hospital. It was perceived that when parents are overwhelmed with these challenges, it is difficult to get their full cooperation and involvement (Ygge, 2007). It is, therefore, necessary for professionals to support parents, as this enables them to help their children in the hospital.

#### 7.4 Setting the findings within a broader religious, medical and legal context

Having discussed the findings of this research in relation to the existing literature on FCC, it is also deemed important to discuss some of the findings, which largely mirror some beliefs, values and culture, mainly religion and traditions that impact on healthcare. Legal dimensions of some of the findings, which may and may not have consequences for family involvement, and yet equally important in the care of the sick child are also highlighted. The three areas of focus under this section are related to religious beliefs, legislative provisions and the culture of the medical system of this research context.

##### *7.4.1 Religious dimensions of child illness and care*

Religious beliefs and practices is a common phenomenon in Ghana which influences all aspect of life, including health practices (Mbiti, 1990). This study identified that participants' religious beliefs influenced perceptions and practices of childcare in the hospitals. For example, some parents attributed their child's accident to spiritual causes and this influenced their emotional reactions. In the African context, there are different beliefs about disease causation from spiritual perspectives. Children particularly are perceived to be vulnerable to spiritual attacks, which manifest as diseases. Some others also share beliefs that the spirit of parents lives in their children. Hence, children become a point of target for the enemies of their parents. It is interesting that some societies also hold the beliefs that children are wandering spirits who may decide to return to their spiritual world if they are ill-treated in the family (Salm and Falola, 2002; Falola, 2000).

Although the religious causes of diseases in Africa portray cultural fictions, which are devoid of empirical validation, the speculations of these beliefs among societies influence perceptions and health practices. It is unsurprising that religiosity is found to be associated with higher parenting satisfaction among parents of African origin (Henderson, Uecker and Stroope, 2016). This study identified that parents who perceived spiritual causes to child's accident were emotionally disturbed. Although the beliefs about spiritual causations of ill-health of children is a common phenomenon in Ghana, evidence suggests that parents often shy away from discussing such spiritual beliefs with health professionals in hospitals (Gold et al., 2013a; Farnes, Beckstrand and Callister, 2011). Arefjord

et al. (2002) reported that the use of supernatural explanations as possible causes of the illness resulted in poorer emotional outcomes.

The role of religion and faith in God as a coping mechanism for patients with other medical conditions have been reported within the African context (Ursaru, Crumpei and Crumpei, 2014; Abernethy et al., 2002; Elizabeth Rippentrop et al., 2005; Olson et al., 2012). For example in Ghana, Donkor and Sandall (2009) explored the coping strategies among women treating infertility in hospitals. The findings revealed that majority of the women prayed and believed in God as one of their ways of coping with infertility. The use of religion as a coping strategy by families of patients with other life-threatening medical conditions is well documented. Abernethy et al. (2002) reported that low to moderate religious coping was related to low depression in spouses of lung cancer patients in a study conducted in the United State of America. This suggests that the spiritual wellbeing of patients and families during hospital admission is as important as their emotional, physical and social wellbeing.

#### *7.4.2 Setting boundaries*

This subcategory described the nurses' accounts of having control over family involvement, which is aimed to maintain order on the ward and to avoid the encounter with uncooperative parents. Similar to this finding, Paliadelis et al. (2005) and Hewitt (2002) in separate studies reported that nurse participants in their studies shared the belief that nurses must make decisions about roles and assign a task to family carers. Based on the nurses' assessments and

assumptions of parental motivation and skills, tasks are assigned to parents in the hospital (Paliadelis et al., 2005; Hewitt, 2002). Brown and Ritchie (1990) also reported that nurses view their control over parental roles as part of their gatekeeping responsibilities.

Generally, the cultures within healthcare organisations are shaped by the beliefs and values of staff and management personnel (Jericó, Peres and Kurcgant, 2008). The organisational structures, technical procedures and rules are collectively designed and enforced through a combination of formal guidelines and informal arrangements. In the context of this research, hospital policies and regulations regarding family involvement have a significant informal component, which draws on the senior nurses own views rather than an institutional imperative. Professional practice, in relation to family involvement, therefore taps into these shared local beliefs and values, to remain relevant and responsive to organisational requirements, whilst providing the healthcare needs of patients.

The drive to maintain discipline and order in hospitals, as perceived in this study, has roots in the philosophy and pedagogy of teaching hospitals. In these professional learning environments, clinical health educators place greater emphasis on the maintenance of professional standards, as a means to preserve the institutional integrity, to safeguard operational accreditation, and to conform to international practices and standards (Akukwe, 2008). Teaching professionals, at this level, project a sense of responsibility to maintain high standards of care delivery. They also strive to improve the quality of services and to plan and

enhance a positive image of the health system, its staff and infrastructures. Thus, in the quest to achieve professional and institutional excellence, patients and their families are required to comply with professional orders, in which sense, depict a misplaced priority and misinterpreted professionalism.

Consequently, the perception of uncooperative and difficult parents emerges when parents flout the orders of the health professionals or question decisions they make. The perceived difficulties posed by uncooperative parents is seen as a drawback to the realisation of these institutional objectives. This follows the logic that parents in hospitals are required to be acquainted with institutional norms and behaviours, which govern the hospital environment (Andersen, 2004). Meanwhile, the findings of this study identified that the set boundaries regarding family involvement exist as informal institutional guidelines and policies similar to the findings of Coyne (2008). Coyne (2008) addressed such informal guidelines related to parental involvement as unwritten rules and hidden policies, which are premeditated to control parents' presence and movement within the children's unit. Such practices may seem to fly in the face of the code of professional conduct. It is therefore unsurprising that some authors perceive the application of such informal guidelines as a way to maintain and preserve professional power and identity and control over hospital environment (Paliadelis et al., 2005; Hewitt, 2002).

On the other hand, the rules, regulations and policies that define the institutional framework within health institutions are essential in the Ghanaian context. This is

because, in Ghana, the boundaries between formal and informal arrangement often become blurred, due to the influence of local traditions, customs and practices. For example, a social phenomenon, which is prevalent in Ghanaian society, is the pre-eminence of informal social arrangements over formal relations. This phenomenon is deeply rooted in the transactional principles of community mutuality, communalism, and reciprocity. These informal arrangements utilise friendships, acquaintances, clan and family networks on which Ghanaians draw to negotiate the complex medical system (Andersen, 2004; Atinga, Bawole and Nang-Beifubah, 2016). Evidence from this research supports the above argument discussed in section 7.2.2. Given the significance of these informal arrangements in transactional interactions, it is therefore not surprising that hospital staff consciously work to minimise its impact and the resultant chaos that it can create. However, the informal approach of health professionals in the application of the rules and guidelines also seems to undermine the principles of family involvement, which may not necessarily be the intent of health professionals.

Corlett and Twycross (2006) and Feeg et al. (2016) in separate studies reported that when nurses exercise power and control over the care roles in hospitals, it prevents shared decision-making, and parents felt disempowered and deskilled in the process. Patients and families in this study demonstrated largely, limited negotiating power with the health professionals. Two phenomena perhaps accounted for parental limited negotiating powers; the perceived hierarchy of powers and control within the clinical environment, which seems like a hurdle to



overcome in a limited time of a child's admission and parents inability to communicate openly with clinicians as discussed in section 7.2.2 and 7.2.1.

#### *7.4.3 The medico-cultural practice and health service delivery*

The study identified that the culture of health service organisation and practice within this study context influenced the practice of parental presence and family involvement. The study contexts, described in section 4.2 are both tertiary referral hospitals. Service organisation of both hospitals epitomise teaching hospitals where excellence is emphasised. The administrative managements, largely based on hierarchical arrangements, guided policies and operations within the clinical environment, which influenced parents' presence and family involvement.

The findings identified that policy as espoused by the senior nurses was crucial in aiding parental presence in the hospital. This was evident as most parents reported that they were informed that the hospitals' policies do not support parental presence. The health professionals reported that at the time of data collection for this study, there was no such policy regarding family involvement. A review of both hospital visiting policies by the researcher confirmed this assertion. The absence of clear policies in both hospitals perhaps accounted for the different attitudes among professionals towards family involvement. It was revealed that some professionals involved parents out of kindness. Smith (2010) asserts that there must be policy evidence that supports the child and family as participants in care. This is a prerequisite for establishing a collaborative working relationship with children and their families, and a means to build rapport for an

effective communication and role negotiation for mutual gains. The absence of policy perhaps instigated the inclination for parent participants to explore alternative caring approaches.

Traces of tensions between parents and professionals existed as parents perceived that professionals were inconsistent in communicating the hospital policies on parental presence. These inconsistencies in communication and practice echoed the findings of Andersen (2004) that when professionals stereotype parents of belonging to the low social class status, they are given less information and attention.

Parents' involvement, particularly in sanitation duties, epitomises the emphasis on environmental hygiene practices of teaching hospitals. Teaching hospitals in Africa are associated with the highest standard of cleanliness and safe waste disposal of used medical equipment, as compared to other level facilities such as the district and regional hospitals (Akukwe, 2008). Consequently, the leadership of teaching hospitals are always preoccupied with the cleanliness of the infrastructure, environment, and equipment and even staff (Akukwe, 2008). It was therefore not surprising that parents were also involved in these cleaning activities of the wards as ways of negotiating their acceptance to stay with the children in the hospital. This suggests that families have to demonstrate a high level of cleanliness and the readiness to offer a helping hand to be allowed to stay with the child in the hospital, which probably could be one of the hidden rules.

The management of child orthopaedic conditions at the teaching hospital is placed under adult health services. The rationale for this arrangement was not clear as none of the participants could justify why the unit was not under the paediatric unit. The staff applied the visiting rules for the adult wards to the child units under their departments. Although some staff were genuinely sensitive to the parents and the child's needs, the nature of managerial hierarchy was such that decision-making goes beyond individual and unit level. Jericó, Peres and Kurcgant (2008) assert that the strength of culture and power in health organisation determine the work relations, which commandingly nurture dynamics of practice traditions. Therefore, any conceivable change to practice requires managerial influence through the processes of negotiations.

Coleman and Smith (2010) assert that inter-professional collaboration is necessary to promote a health care delivery approach, which focuses on meeting the needs of patients and families. This highlights the importance of teamwork approach in the clinical settings to promote family involvement. Traditionally, the health professionals in this research context organise clinics and services in separate teams. Thus, patients are admitted into different medical teams, which are responsible for their care. Interestingly, medical teams consisted of only consultants, surgeons, house officers and medical students. Nurses and other professionals, although important service providers, are not integrated into the traditional medical teamwork practice in the hospital. In teamwork, ideas are discussed and collective decisions, which represent the best interest of the patient overrides individual sentiments and opinions. Therefore, if the nurses'

decisions on patient care forms part of the agenda for the professional team discussions, this will mitigate the senior nurses' sole power over family involvement. Follett (2006) identified that lack of support among professionals significantly obstructed the practice of FCC. Furthermore, ineffective teamwork is a barrier to positive interaction among staff, which could hinder discussions towards promoting attitudinal change in favour of the practice of FCC (Follett, 2006).

Power and control structures within the health service and administration system in Ghana promote hierarchical relationships between doctors and nurses. The phenomenon has its origins in the entry requirements and selection criteria traditionally used to recruit students into the medical profession in higher education; thus, the measure of intelligence, which qualifies students into medical schools places emphasis on high academic achievements. This creates the perceptions that other related professionals like pharmacy, nursing and laboratory officer candidates, and the largest health trainees are just above average or average students. This approach lays the foundation for the power differentials and communication challenges reported in the findings of this study. It is a common knowledge that this phenomenon creates divisions between doctors and nurses from the onset of their professional journeys over the years. The approach to teaching also follows similar traditional mode whereby the different health professionals are trained differently with less attention to inter-professional education. Preparing health professionals for effective collaborative practice enabled the practice of patient and family centred care (Swanwick,

2013). Thibault (2013) suggest that a good practice of professional collaboration must apply inter-professional education. According to the UK Centre for the Advancement of Inter-professional Education (CAIPE), inter-professional education occurs when two or more professionals learn with, from and about each other to improve collaboration and quality of care. Currently, in Ghana, there seems to be limited evidence regarding inter-professional education being practiced. This explains the different perceptions among nurses and doctors about the practice of family involvement in this study as evidenced in ineffective inter-professional communication and negotiations.

Nurse educators, managers and administrators also place emphasis on obedience in their professional practice. Likewise in the professional training programs, educators in Africa rarely encourage students to express their opinions, possibly because some of the educators themselves may have challenges with communication and assertiveness (Mahat and Phiri, 1991). This approach to student-teacher relations further reflects in professional practice and often detrimental to inter-professional communication and interactions.

Considering the statutory powers of the studied hospitals in this research, there are no foreseen impediments for the family involvement policy and practice. The mixed background of the hospitals' managerial board members (health and non-health stakeholders, community representative and one government appointee), which mostly are largely perceived to have no experience in children nursing may contribute to the lack of updated policy on the family presence and involvement.

There is evidence that unbalanced staff manager representative on administrative committees negatively influence the optimism for facilitating practice change towards FCC practice (Lee, 2004; Follett, 2006). The resultant effect of the lack of policy on FCC is, therefore, the inconsistencies in family involvement reported in this study and other research (Follett, 2006). This highlights the essence of the support for family involvement sub-category identified in this study, and further suggests the need for the advocacy role of clinicians of children units to influence policy change.

#### *7.4.4 Legislative instruments and executive policies on childcare*

The policy instruments with respect to the wellbeing of children irrespective of their age, culture, religion, location and state of health can be located in United Nation (UN) Convention on the rights of the child. In 1989, the UN General Assembly unanimously adopted the Convention on the Rights of the Child. The Convention consist of fifty-four articles, with a broad scope of focus and culturally friendly to nations of the world. Subsequently, almost all nations including Ghana have since endorsed and adopted it. During data collection, one of the orthopaedic surgeons interviewed in this study questioned the essence of Ghana as the first country to endorse the United Nation (UN) Convention on the rights of the child, and yet lacks its applications in childcare. Indeed Ghana has also signed the first of the regional treaty on children, the African Charter on the rights and welfare of the child and these legal instruments are expected to influence the country's policies on childcare as well.

Significantly, Ghana has made progress in legislation and social policy development for the protection of children during the past two decades. For example, Article 28 of the 1992 Constitution of Ghana guarantees the rights and freedom of all children in Ghana. Similarly, in accordance with the principles of the UN Convention, the Parliament of Ghana passed The Children's Act in 1998, (Act 560). Subsequently, many other complementary legislative instruments and policies guidelines for children have emerged. These include, National Policy Guidelines on Orphans and other Children made Vulnerable by HIV/AIDS (2005), National Social Protection Strategy (2007), Child, and Family Welfare Policy (2014).

Analysis of all these legal frameworks and policies in Ghana, including the establishment of the Ministry of Women and Children's Affairs, potentially provide safety matrixes for the vulnerable children. However, there seems to be no policy regulating the care of the sick child, particularly for the hospitalised child. For example, facilities in the hospitals were only provided to cater for children up to age twelve. Children above the age of twelve were treated like adults and cared for in adult units. This clearly does not accord with the international and Ghanaian definition of a child as a person under the age of 18 years.

The care of the sick child in the hospital is also centred on the frameworks of the UN's Convention on the Rights of the Child (United Nations, 1989), the African Charter on the Rights and Welfare of the Child (Organisation of African Union, 1990) and The Children's Act (1992), Ghana. For example, under section two of

The Children's Act (1998) of Ghana, the basic duties and responsibilities of parents and families towards children are presented. These includes parental availability/access to the child and continuous parenting of children, provision of social amenities including health and education; protection from harm, neglect, abuse and discrimination; provision of guidance, care, assistance and maintenance; and ensuring that in the temporary absence of parents, children are left in the care of competent adults.

Other international organisations such as the Institute for Patient and Family-Centred Care, the National Centre for Family Professional Partnerships (NCFPP), the Joint Commission, have recognised that the international definition of the child as anyone between ages zero to eighteen years in many different countries. Furthermore, the role of parents and family as constant participants in the child's life is crucial. This, therefore, suggests that preventing parents from performing their responsibilities for children in the hospital may result to violating the child's rights and denying parents their right of responsibility to care.

## 7.5 A conceptual framework of active family involvement as the new addition to knowledge

This final section of the discussion brings together key findings from both data and literature to outline a conceptual framework of family involvement for the care of the injured child in Ghana. This research, to the best of my knowledge,



following an extensive review of the available literature is the first of its kind conducted within the Ghanaian context and therefore a new addition to knowledge in this milieu. Many studies in the past have focused on different dimensions of FCC in Europe and other western cultures (Coyne et al., 2011; Shields and Nixon, 2004; Shields, 2007). Only few studies have been conducted within the African context and most of these are from Southern Africa. This research into children involved in RTA is unique, hence an addition to the existing body of knowledge.

In line with the assertions of Birks and Mills (2011), grounded theorists need to consider ways to increase the value of their research findings. It is therefore imperative that this grounded theory research provides an answer to the question “how can I package the knowledge discovered to increase its practicability and also make its utilisation appealing for a change in practice?” In this regard, a force field analysis was deemed helpful in providing a theoretical framework to illustrate the perceived elements of family involvement as discovered in this research.

Kurt (1943) developed a theoretical framework called the force field analysis, which is a composite planning tool used to identify a network of factors that affect decision-making processes. It is a framework for problem-solving and a plan towards change in organisational management (Schwering, 2003). The framework is used to elaborate diagrams of the directional field of forces to illustrate the nature of strength and the influence of relevant factors on the field of change. According to Lewin, Lewin and Cartwright (1997), a field or life space

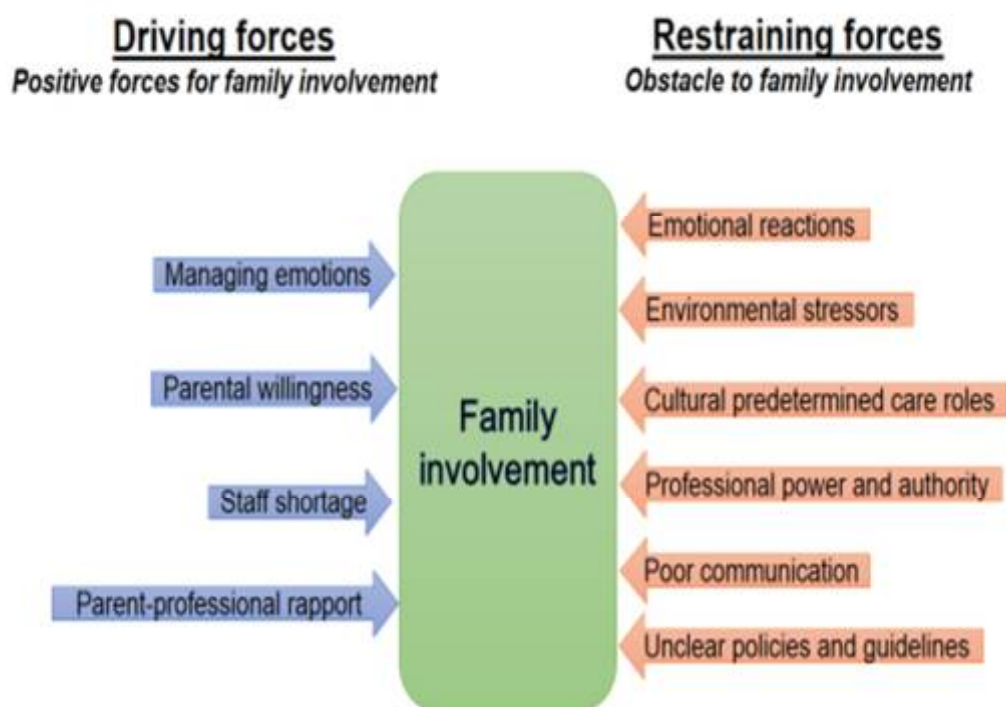
of a group consists of the group and its environment as it exists for the group. The state of the group and that of its environment are in constant interaction to maintain equilibrium or stability. It, therefore, follows that behaviours are dynamic balance of forces working in opposite directions (Kurt, 1943). Hence, driving forces and restraining forces are crucial for any changes to occur.

In this research context, the life space consists of parents, the injured child and health professionals in the hospital environment. All these participants are functioning together for the stability of the injured child and their families. Parents perceived parental presence and the professionals perceived family involvement to enable the achievement of the desired stability of the sick child and family. Parental presence, according to this research is the parents' constant physical presence, active participation in the basic childcare, as well as staying informed about all aspects of care in the hospital. On the other hand, family involvement refers to a relationship between nurses, patients and family, whereby the nurse is in control of the interactions in this relationship. Drawing on the two perspectives, both parental presence and family involvement advocate for a family-oriented approach to care founded on the premise of a cooperative and supportive relationship between families and healthcare professionals.

The elements of the two concepts (parental presence and family involvement), together construct a theoretical framework of family involvement (figure 7:3), which constitute the key findings from this research. The framework, which adopts the force field analysis, outlines the restraining and driving forces (figure

7:3) that influenced the practice of family involvement perceived by participants in this research.

Figure 7.3 Force Field Analysis: A conceptual framework of family involvement for the hospitalised injured child in Ghana.



#### *7.5.1 The restraining forces of family involvement*

This study provides a unique insight into restraining forces of family involvement within the Ghanaian context. These forces mostly stemmed from the existing protocol of care of the child in hospital, which lack evidence of clear clinical guidelines for parental presence and family involvement. Regarding parental presence, several parental emotional reactions are perceived to hinder parents'

active participation in the child's care. These emotions include blame and guilt, anxiety and worry, sadness and fear.

Parents desire to actively participate in the basic care of the sick child is also influenced first by acceptance to the ward and second, the ability to negotiate the desired roles to perform. The findings from this research revealed that environmental stressors such as overcrowding in the wards, busy work environment, and the complex injuries of patients are key restraining forces to family involvement. To put this into perspective, health professionals' in this research context placed importance on the maintenance of orderliness and environmental cleanliness of their units. In so doing, the high standard of professional practice stipulated in the professional code of ethics for practice in Ghana (Ghana Health Service, 2017) is often undermined.

Another major restraining force is cultural norms and patriarchal system, which predetermines care roles. In the Ghanaian socio-cultural context, the basic care of the child, whether sick or well are perceived as female roles (Akujobi, 2011; Grantham-McGregor et al., 2007). The presence of the male parent in the hospital is, therefore, perceived unusual and often not valued. Furthermore, the biological mother of the sick child is preferred at the hospital over other members of the family. In most cases, the siblings of the sick child who may be potential family caregivers are not welcomed to the ward due to age restrictions. These socio-cultural orientations to caring for the child, which influence decision-making

processes of staffs affect the involvement of the entire family, and therefore perceived as restraining forces to family involvement.

The imbalance in power and authority between the professionals and parents is another area of challenge for family involvement. Parents perceive that health professionals are of higher social status due to their knowledge attainment in the field of health. Within the Ghanaian socio-cultural context, the attainment of formal education is linked to intelligence and power (Andersen, 2004). Furthermore, professional career or “white colour job” is also associated with wealth and power (Andersen, 2004). Wealth and power structures are therefore fundamental to the classifications of individuals into hierarchies of social order. Health professionals’ perceived of higher social status is therefore unique to the Ghanaian context. Such social classifications affect parents’ negotiation power and skill and therefore identified as one of the restraining forces to family involvement.

Similarly, the health professionals perceived that formal educational attainment has correlations with biomedical knowledge about disease occurrence, prevention and control. Thus, the level of formal education of parents influence the ability to process information related to childcare in hospitals. Hence, health professionals are reluctant to provide the necessary information about childcare on grounds that parents may not understand or value the quantum of information given to them. The minimal information given to parents thus contributes to poor

communication. This study therefore provided a unique insight into the influence of poor communication and language barriers to family involvement.

According to the health professionals, a major restraining force to family involvement is the lack of clear policy on family involvement or FCC. This study is first to report that there is no such evidence of guidelines for clinical practice regarding parental presence, information sharing and communication. Institutional support in the area of infrastructure to accommodate families is also viewed policy issues, which is crucial to family involvement. The literature reported that the evolution of maternal presence was characterised by the creation of additional hospital space to accommodate mothers and their sick children (Coyne, 1996). These unique insights suggest that without efforts to provide policies and infrastructure to support families in hospitals, all the research, education and recommendations regarding family involvement will remain as theoretical concepts without their full application in practice.

#### *7.5.2 The driving forces for family involvement*

A major finding of this research is parents' motivation and willingness to be part of the care team in hospitals. Ghanaian culture and traditional practices of caring for the child emphasise on the proximity of the mother to child (Pollard, 2006). This notion is key to the category, parental presence. Therefore, the key driving force to family involvement is rooted in the willingness of parents to be present in the hospital and to participate in the care of the sick child.

On the other hand, for the first time reported from the Ghanaian context, health professionals identified persistent staff shortage as one of the major driving forces for family involvement. As such, parents' preparedness to perform basic tasks for children in the hospital, to assist nurses in clinical chores to maintain cleanliness and to run errands for the staffs are driving forces for family involvement. This phenomenon stemmed from the emphasis placed on the cleanliness of hospital environments in sub-Saharan Africa, especially, tertiary hospitals such as teaching hospitals (Akukwe, 2008). Hence, a rationale for parental presence is to support the clinical staff to maintain the cleanliness of the children's unit.

One other key driving force identified in this research was the ability to manage parental emotions. Among the approaches to managing parental emotions, include keeping parents informed about the child's condition and progress to allay their fears and anxieties. Religious practices were also key factors in managing parental emotions and this was evident in the literature from the Ghanaian context (Ursaru, Crumpei and Crumpei, 2014; Olson et al., 2012; Donkor and Sandall, 2007). Religious practices such as prayers and fasting for the sick child, and trusting in divine interventions for healing help families to cope with emotional stressors in the hospital.

Parents' ability to establish good rapport with the professionals is key to family involvement. One such strategy from the findings of this research is the parents' ability to negotiate their social status to get recognition and acceptance in the ward. It was realised that negotiating ones' social status in this regard involves

the process whereby parents make themselves feel important and valued. This unique way of parental negotiation in the hospital system is a new addition to knowledge in the care negotiation milieu.

Another driving force to family involvement is the strategy of striking acquaintances with individuals of higher ranks in the hospitals or any influential figure in the society. This finding is one, which is unique to the context of Ghana. The perceived influences of such individuals are used to negotiate with health professionals to gain constant access to children in the hospital. This is also perceived as a system negotiation approach common in the Ghanaian socio-cultural context (Atinga, Bawole and Nang-Beifubah, 2016; Yeboah-Assiamah et al., 2016).

To conclude this section, it is important to provide a direct answer to the question, “how do parents and health professionals perceive Family Centred Care (FCC) for children hospitalised through RTA in Ghana?” This was the research question outlined at the beginning of this study. The above discoveries reveal that the FCC is not a concept practiced in Ghana. However, in the absence of FCC, parents perceived parental presence and the health professionals perceived family involvement as essential to the FCC process. Both parental presence and family involvement are desirable concepts, but practiced inconsistently in Ghana.



## 7.6 Conclusion

In conclusion, this study is the first to demonstrate that parents and families in Ghana have a strong desire to be part of the hospital care for children hospitalised through RTA. Parent's willingness to participate in care was demonstrated with intense emotions, interest in participating in care, and persistent lobbying skills to negotiate their stay with the children in the hospital. These were not without challenges. Management dynamics and traditions of care practices in the hospital pose challenges to parental presence and participation in childcare. Health professionals, by their generic training, have also demonstrated knowledge on the FCC concept as being family involvement. Allowing parenting in the hospital and involving them in housekeeping chores were some of the roles professionals embraced. Professionals viewed communication as the key facilitating factor in enabling parent-professional interaction and active practice of family involvement. The key findings from this research, which constitute new additions to knowledge, were presented as a conceptual framework of family involvement in the context of Ghana.

## 8 Chapter 8: Conclusion and recommendations

### 8.1 Introduction

This final chapter renders an evaluative account of the reflexivity, methodological and procedural coherence. The strengths and limitations of the study are the other highlights of this chapter. The implications of the findings for education, policy, and practice, which inform avenue for future studies, are also outlined.

### 8.2 Evaluation of the research process- Personal reflections

Qualitative research has been challenged on its trustworthiness over the years (Creswell, 2013; Braun, Virginia., Clarke, Victoria, 2013; Strauss and Corbin, 1990b; Chiovitti and Piran, 2003; Annells, 2007). Naturalistic and interpretive nature of the approach attracted labels such as undisciplined, sloppy, purely subjective and untrue accounts of knowledge (Lincoln and Guba, 1985). Questions relating to 'truth' of findings are important to establish confidence in the study outcome (Annells, 2007). Although qualitative studies are not aimed at generalising results, the fitness of procedure to achieve the same or similar outcome when repeated or conducted elsewhere with identical conditions must be established. Thus, transparency must be shown throughout the research process to minimise any form of doubt about the findings (Lincoln and Guba, 1985; Needham, 1999).

There are no uniform ways of evaluating the trustworthiness of qualitative research processes; however, Charmaz (2014) proposed criteria for evaluating a grounded theory research. These include the determination of the credibility, originality of the findings, resonance, and usefulness of the study outcomes. According to Charmaz (2014), an evidence of a strong originality and credibility increases resonance and usefulness, and the subsequent value of the contribution to knowledge.

The credibility and trustworthiness are achieved when the research attain intimate familiarity with the setting or the topic. A credible qualitative research refers to a detailed description of participants' experiences and accounts, in that the participants can easily identify with the outcome of the study (Beck, 1993). Credibility is also attained if significant others such as professionals and researchers could identify with the process and findings just by reading the research report (Cooney, 2011). Charmaz (2014) suggests that the originality should provide new categories, and fresh insight of the concept studied. These must also have social and theoretical significance to ensure the relevance of the study (Hunter et al., 2011b).

Although the Charmaz (2014) sets of criteria for evaluating the trustworthiness is akin to that of earlier authors (Lincoln and Guba, 1985; Mauthner, 2002; Chiovitti and Piran, 2003), these criteria do not in themselves ensure the quality of research. A highlight of the processes adopted in this study to ensure the trustworthiness of the grounded theory is discussed in the next sections.

### *8.2.1 Researcher reflexive responsiveness-The insider outsider positions*

According to Koch and Harrington (1998), qualitative researchers have a responsibility to engage in self-critique and self-appraisal. This is often reported as a reflexive account. Reflexivity refers to the awareness of how researchers' experience influence the process and product of the research (Koch and Harrington, 1998; Colbourne and Sque, 2004; Allen, 2004). Constructivist grounded theory beliefs allow researchers to bring to bear their professional background in the conduct of the study; for example, during engagement with research participants and active influence in data generation and analysis (Charmaz, 2014; Hunter et al., 2011). Hence, the reflexive account forms one criterion to evaluate credibility in grounded theory studies (Chiovitti and Piran, 2003; Jootun, McGhee and Marland, 2009).

An attitude of self-awareness and reflexivity was established and documented right from the conception stage of the study. My professional background as a paediatric nurse and past encounters with children involved in RTA at various hospitals in Ghana are outlined in section 1.2 and 1.3. Furthermore, my worldviews and philosophical assumption regarding the topic under study are outlined in chapter three. My worldview assumptions informed the exploration of the ontological and epistemological underpinnings, which guided the selection of constructivist grounded theory approach to this research.

Setting the stage regarding my ideological thoughts as well as my professional background and cultural identity, which have many commonalities with the

research participants, suggest a few advantages and disadvantages in the research conduct. These declarations therefore positioned the discussions in the insider outsider debates in the qualitative milieu. According to Serrant-Green (2002), elements such as indigenes researching within their cultural context, having local knowledge and experience with the topic and research area and also having professional and familial connection with participants places the researcher in the insider status. The perspective of the researcher viewed as an outsider in my case relates to what Serrant-Green (2002) describes as the researcher also doubling as a young academic. Thus, the element of being a black academic, a novice researcher and living in and reporting in an affluent western culture where only a few have insight into contextual differences underplay applied in my case.

My insider positionality at both research sites (hospitals) was straightforward and unproblematic. Appointments with gatekeepers were honoured and approval was given based on familiarity with personnel and settings. Similarly, I gained significant cooperation from several staff members and parents. I was also aware of the possibilities of issues relating to power imbalances in the field, which was likely to result in exploitation of potential participants. However, I took extreme care to respect and protect participants.

There were a few anxieties and dilemmas about blurred boundaries and role ambiguity. For example, on occasions of my field trip, there were some days that nurses encouraged me to feed sick children while their parents were out of the

ward. I observed that for the act of reciprocity, such offers from me could trap parents to participate in my research, which may be unethical. Also, on few occasions, some parents expressed a desire to use me as a mediator between them and the health professionals. On both occasions, I politely explained the ethical implications of such requests to them, in relation to the performance of these roles outside my researcher positionality. I employed a great deal of tact and diplomacy in negotiating these challenges.

The challenges as an outsider relate to suspicion among colleague potential nurse participants. For instance, as I narrated in chapter four, nurses were initially reluctant during their recruitment. They were suspicious of some hidden agenda about the research; hence, they expressed interest in knowing the findings from the parents' interviews. I reassured them and emphasised the purpose and aims of the research.

Also, dealing with issues related to objectivity and subjectivity in reporting findings were inevitable. Strategies employed included memo writing in the form of reflective journaling. Throughout the study, my thoughts processes, decisions, rationales, and feelings on various aspect of the study were memo recorded and tabled for open discussions with my research supervisory team at scheduled monthly meetings. In the data analysis phase, I employed the strategy of co-construction of knowledge through mutual interaction with participants (Charmaz, 2014). The codes that emerged from the raw data and used to develop categories and subcategories were shared with the study participants for their necessary

contributions. An attitude of openness and flexibility adopted during data collection and analysis helped to gain theoretical sensitivity (Walls et al, 2010; Charmaz, 2014). In line with Morse et al. (2002), preconceived ideas that were not supported by the data were discarded.

#### *8.2.2 Methodological and procedural coherence- A contextual adaption of constructivist grounded theory method*

Methodological congruence considers the researchers' philosophical position, research objectives and methodological approach employed to achieve the stated objectives (Charmaz, 2014). It cannot be over emphasised that whether being conscious of or not, our ways of viewing and thinking about the world and how we perceive nature and its operations influence our approach to research questions. Nevertheless, one of the fundamental beliefs in constructivism is that although individuals' experiences are unique, the findings in one context can fit in another. Therefore, quality is demonstrated when details of the scope and context are well documented, and there is enough evidence of consistency in decision trail regarding these. Hidden ideas, goals, and processes question the quality of a study and hence negatively affect the credibility of the researcher and research outcomes (Creswell, 2013).

I began this research with an appreciation of the multiple interplays of factors such as social context, interaction, multiple opinions and interpretive understandings in constructivist grounded theory methodology (Lincoln and Guba, 2013; Charmaz). This ideological perspective to knowledge generation

falls in line with the African values for “*Ubuntu*” concept (Schreiber and Tomm-Bonde, 2015). Therefore, Charmaz (2014) perspectives of co-construction and constant comparison in theory generation were brought to bear in the conduct of this research.

For example, in reaching for a rich data, I outlined in chapter 4, the unique characteristics and roles of the two tertiary hospitals in relation to accident and trauma care in Ghana. I applied the concept of co-construction in drafting the participants’ information sheets and interview guides prior to the data collection. Potential participants contributed to the language of the information in both documents, which helped participants to understand the research objectives. Also, researcher-participant interdependence and mutual respect guided the process of participants’ recruitment for interviews and data collection. For example, the participants’ enthusiasm to participate in the research was respected. Hence, the interviews were often conducted in clusters of two and three at each field trip. It was one of my flexibility in adopting grounded theory method and also my reflexive application of constructivist grounded theory method in this research. Furthermore, the concept of theoretical sampling was applied in recruiting nurse managers who by their duties were not directly at patients’ bedside. Similar concept was applied in recruiting the orthopaedic surgeons to the research.

Constant comparison method of data analysis was employed to arrive at the emerging concepts of parental presence and family involvement. I used the line-



by-line coding at the initial stage of open coding to identify the initial emerging concepts. Codes were compared for similarities and variations in dimensions. The comparison was conducted throughout the three stages of data analysis, thus, opens coding, focused coding and conceptual model development. It also explains the reason for the large sample size as saturation was sought in data collection.

As data analysis advanced, I planned and organised focus group discussions on emerging concepts. I employed an innovative approach in co-constructing knowledge, which fit the Ghanaian context. Schreiber and Tomm-Bonde (2015) ascribe to the value of communality within the African culture. In line with this understanding, I invited the participants in the individual interviews to participate in group discussions. These discussions validated emerging codes and concepts. Adopting focus group discussions to arrive at a consensus on emerging codes and categories was another key process I perceived in social constructivism (Charmaz, 2014).

In line with Charmaz (2014) appreciation for memo writing, I kept a hand written reflective diary during data collection and analysis to achieve openness and clearness on processes, procedures, and outcomes. In an under-resourced context like Ghana, where continuous availability of electricity is not guaranteed, capturing memos with electronic devices could be problematic. I was comfortable writing in my personal diaries, which was purposely for this research. I also opened the research to public scrutiny. This took the form of conferences and

seminar presentations, and participating in poster competitions. I also invested time and efforts to attend frequent monthly supervisory meetings. Through the recordings of personal progress report after such meetings in complying with the institutional research processes, I enhanced the trustworthiness and credibility of my research.

Finally, I approached my thesis write-up with the mind-set of providing a detailed description of categories and subcategories with several supporting verbatim quotes. Essentially, my goal is to assist readers to corroborate the findings over time and across similar situations related to the context of my research (Chiovitti and Piran, 2003). It also provides the foundation for interested readers to understand and judge the relevance of my findings to the context of Ghana and other settings of similar characteristics as Ghana.

### *8.2.3 Theoretical concepts development*

Enhancing auditability in grounded theory research enables another researcher to replicate the study in same or similar context to arrive at similar conclusions (Chiovitti and Piran, 2003). To ensure auditability, therefore, requires a process whereby the researcher demonstrates decision trail of all the decisions at every stage of the data collection to the analysis and to the stage when the final theory emerged. Appropriate for a grounded theory research, data gathering and analysis in this study occurred concurrently (Charmaz, 2014). Data collection and analysis was a back and forth process. However, the strategy of frequent memo writing and recording of all the proceedings at supervisory meetings altogether

reflected the maturity and abstract thinking. Data management involved the preservation of the originals interviews, which were constantly used to compare with other interviews, emerging codes, and categories.

Due to the newness of the concept investigated in the study context, as well as the translation of data, verification and validation were necessary for this study to achieve originality and resonance Charmaz (2006). In this regard, two processes were applied; individual member-checks and focus group consensus on categories developed. Individual member-check was used in the study to confirm and validate information gathered from participants. It involved the process whereby all the translated transcripts were crosschecked with participants to ensure that their views were recorded correctly, and the exact views were transcribed. In the case of the participants who granted interviews in languages other than English, the translated transcripts were read and interpreted in their spoken languages. A majority of the participants validated their transcribed data.

Almost all participants included in the individual interviews formed part of the focus group discussions to reach a strong consensus on codes, categories, and subcategories that emerged from the data. This approach falls in line with Charmaz (2014) idea of co-construction of the research process and theory development.

A vivid and faithful description of a phenomenon studied; with evidence reflecting that participants in the study guided the inquiry process further contribute to the

credibility and trustworthiness of the emergent theory (Chiovitti and Piran, 2003). The initial codes in this study reflect the language of the participants, which ensured that subcategories and the categories stayed close to the primary data. Although the original research objective of the study was perceptions of FCC for children involved in RTA, the initial emerging codes revealed concepts different from the FCC. Thus, with a modification in interview guides and changes in the languages used in questioning, which reflect participants preferred choice of terms, the outcome categories revealed two different prevailing concepts, parental presence and family involvement instead of FCC.

### 8.3 The strength and limitations of the study

Regarding the methodology of choice for this study, the adoption of Charmaz version of the constructivist grounded approach is a strength to this study based on several considerations such as contextual appropriateness and the subject explored. In line with the philosophical ideologies of symbolic interactionism, people construct selves, society, and reality through interaction (Charmaz, 2014). Schreiber and Tomm-Bonde (2015) assert that the African culture and values, which are grounded in principles such as interdependence, mutuality, reciprocity, and communalism reflexivity, are in congruence with the tenets of constructivist grounded theory methodology. Furthermore, Charmaz (2006) acknowledges that research roles can distance indigenous scholars from participants. Hence, the importance attached to relationships with participants during the data collection and analysis is akin to the constructivist perspectives of researcher-participants

co-construction of meanings of research processes and outcomes (Schreiber and Tomm-Bonde, 2015).

This study intended to explore perceptions on FCC. Despite this initial focus, I also recognise that although qualitative researchers construct research processes and product, these processes may be influenced by pre-existing structural conditions and emerging issues (Charmaz, 2014). Therefore, the emerged concepts family involvement and parental presence, which were the main and popular concepts discovered from the data, and not FCC, is perceived as a strength in this study. The social construct of the FCC from the western context depicted similar conceptual foundations of the concept FCC about five decades ago. This does not mean that there was a deliberate attempt to force such concepts on the data. However, it reveals the researchers' openness and sensitivity to emerging concepts and constructs. Hence, the findings of the study, which also showed that there is non-existent of FCC in the Ghanaian context, and instead family involvement and parental presence as the prevalent concepts form a foundation for future studies with regards to FCC concept in the Ghanaian context.

Recognising my inexperience as a novice researcher, I stumbled few times drafting the theoretical framework of the study; however, I also acknowledged that this was not unique to me. Charmaz (2014) identified that in writing the theoretical frameworks, researchers are likely to balk, stumble over or perhaps clutter their findings. The application of the force field analysis as the conceptual

framework in clarifying the conclusion after the analytical process of the study findings is therefore not to mean that deductive reasoning applied most in this interpretive study. Rather, it provided the framework to present the practicability of the findings and well as summarises the entire analysis.

Despite the diligence and robustness to methodological procedures and rigour in this research, some limitations were identified. For instance, the study sample, which is limited to only parents and professionals, may be viewed as inadequate in terms of achieving the degree of data saturation that might be desired due to some potentially missing respondents. Recently, the voices of children and their perspectives on the concept of FCC have also been recognised (Shields, 2015). Furthermore, the inclusion of other workers within the clinical environment is likely to present a different perspective to the dimensions of the findings. It is also believed that additional data gathering strategies such as participant observations would have been beneficial to this study. Charmaz (2014) asserts that irrespective of the data gathering methods, a deliberate effort to gather sufficient data to fit the purpose and offer a complete picture of the topic studied is acceptable. It is on this basis that a large sample size of forty-three participants (section 4.2.4) of varied background were recruited and involved in the study.

It is also realised that the conduct of this study in two hospitals all located in the capital city, Accra, and more so, both hospitals being tertiary institutions limited the generalisation of the study findings. It is perceived that the focus of qualitative research is not to generalise its findings (Patton, 2002; Patton, 2015; Parahoo,

2014) which are further emphasised by some grounded theorists (Stern and Schreiber, 2001; Glaser, 1998). Glaser and Stern oppose large sample size, and instead advocate for a sizeable data enough to illuminate properties of a category and dimensions between categories. However, Charmaz (2014) cautioned that attempts to minimise sample might lead to superficial analysis. Although the findings of this study cannot be a representative of the entire Ghanaian perspective, the in-depth data generated was just sufficient for the findings, which revealed the childcare practice in Ghana.

In qualitative studies, the researcher forms part of the research instrument. Thus, data generation and analysis are filtered through the researchers' lens (Patton, 2002). Notwithstanding the adherence to procedures to minimise the researcher influence, subjectivity as a limitation in this study cannot be ruled out completely. It is acknowledged that my familiarity with the context of the study doubled as strengths and weaknesses of the research. For instance, I had limited knowledge, and skills on research conduct at the beginning stage of this study, however, my practical knowledge of the study settings and practices were valuable throughout the conduct of the research. Gaining access to the research settings and participants recruitments happened without incidents. I am also convinced that this same reason accounted for the low attrition rate of participants from the study. There was that display of the African culture of mutual support generally towards the research and me.

The most challenging aspect of familiarity to the research context is the ability to gather and interpret data without imposing the researchers' views on the participants and the research outcomes (Birks and Mills, 2011). This was a typical challenge in this research due to my passion for the FCC concept and the eagerness to experience every aspect of the research process. The concept of reflexive practice suggested in constructivist grounded theory approach was useful in this phenomenon. Reflexivity underpinned the mixed participant involvements (see chapter 4). The large sample size and the validation of emerging codes through the focus group discussions were other reflexive approach adopted. Furthermore, the vital roles of the supervisory team in ensuring that such specific issues relating to personal biases, and their demands to conduct a rigorous study contributed to reducing researcher biases in this study.

## 8.4 Implications of the research findings and recommendations

Both the restraining and driving forces identified in the field analysis provide strong implications for education, practice and policy, and suggestive of possible practical recommendations to improve care for the injured child in hospitals.

### *8.4.1 Implications for education*

The findings of this research are suggestive of parental presence and family involvement as the most preferred concept in the study context and probably within the wider context of Africa (Söderbäck and Christensson, 2008). In this



regard, context-appropriate family involvement concept should reflect in all aspects of the health professional education system. Therefore, it is recommended that an update in curricula across all the health professional programs to include a culturally appropriate family involvement concept, which embraces parental and family presence and participation in care, is important.

Periodic continuous professional education on the concept of family involvement/FCC and its related topics such as parenting, cultural competencies and high standard of professionalization is recommended. This targets clinicians who are already out of schools, based in hospitals and providing care to children and their families. Progressively, in-service training on desired concepts may change professionals' orientations towards family involvement/FCC practice in the Ghanaian context. Positive perceptions and practice of family involvement/FCC among clinicians have the high chances of ripple effects on yet to qualified health professionals.

A holistic care approach to teaching at the professional training level is essential for the understanding of the inclusive approach to care. It is perceived that inter-professional education will promote the expected interaction and communication among health professionals, which will ultimately, improve parents-professional collaboration. It is also important that health educators exemplify high professional standards in teaching practices, and as well educate their trainees on the codes of conduct for health professionals.

#### *8.4.2 Implications for policy*

This study identified that the absence of institutional policy statement regarding family involvement practices stemmed from the limited evidence of national policy on FCC and family involvement. Policies that reduce institutional bureaucracies, provide institutional support and suppress medical model approach to care are key to the desired family involvement. Stakeholders in hospitals in Ghana must be abreast with current trends in clinical practice for children.

An institutional policy on partnerships with families at all levels of care will inform family involvement practices on a daily basis at the ward level. Hence, it is my recommendation that care policies of hospitals must state the emphasis of family involvement, and provide guidelines for the implementation and practice of the family involvement at the children units. This study also recommends a development of practice protocol/toolkits in the areas of family presence during clinical procedures and information sharing.

#### *8.4.3 Implications for practice*

The implications of the findings for practice suggest positive driving forces and suppression of the restraining forces that will ensure the practice of the desired family involvement. The nursing practice and the entire professional body in the clinical environment must uphold the highest professional standards in dealing with patients and their families. In so doing, a holistic healthcare delivery will be ensured. A holistic healthcare invariably is suggestive of an all-inclusive care

practice. It is recommended that professionals must make deliberate efforts to improve the practice environment so that families will feel welcomed. These may be achieved when elements that are of contextual relevance and culturally appropriate are incorporated in care. For example, the health professionals need to reconsider their bias towards only mothers and adopt a more opened attitude towards any other member of the family whom the family chooses to stay with the sick child in the hospital.

It is also my recommendation that the healthcare institutions adopt a change strategy to demystify perceptions about institutional bureaucracies. This can be achieved through a system, which adopts an open communication strategy. Adequate signposts to appropriate offices with the services they offer will contribute to achieving this objective. Families should be encouraged through an open communication system to negotiate care they desire to give to their children in hospitals.

## 8.5 Recommendations

The specific recommendations that stem from this research include the following:

- 1 Hospitals must include their FCC/family involvement positions and orientations in policy statements which are readily accessible to staff and parents. This will serve as motivation to clinical staff and get their commitments to practice it.

- 2 Nurses and other health professionals should be given orientation to and education on the concept of family involvement/FCC.
- 3 Hospitals should consider implementing a patient/parent advisor role to assist families' induction to the institution.
- 4 Hospitals should develop clear written protocols for the involvement of parents/family in the care of the in-patient child
- 5 Future research should focus on children to illuminate the child's perspectives on FCC.

It is anticipated that these recommendations will empower both the health professionals and families for the effective practice of family involvement/FCC in the care of child hospitalised through RTA.

## 8.6 Lessons learned for future practice

As an emerging researcher, I have acquired knowledge and skills from this research process and its outcomes, which will inform my practice within the academic milieu. In the area of teaching, the experience gained from the conduct of this study has influenced my orientation and approach to teaching research methods especially qualitative approaches. My supervisors approach to graduate student supervision, which is supportive enough to ensure students' successful completion of studies have influenced me a lot. I am confident that I will also be able to supervise students in a supportive manner to conduct qualitative research, as well as review their qualitative reports. The experience of successfully navigating the terrains of the medical systems during the conduct of the research

has improved my lobbying and negotiation skills with hospital gatekeepers. These skills will be valuable for any future research for my personal career development.

The successful application of modern technology, the Nvivo, to aid data analysis during the conduct of this research is an essential skill gained, which will forever be priceless to me. They are skills that will come into everyday use in my research practice. I am also thrilled about the ability to use bibliography software managers in the writing of this thesis. Other invaluable skills acquired include poster development, academic writing skills, and public presentations.

Plans for dissemination of research findings include presentations at local and international conferences. In line with the culture of contemporary academic practice, drafts of manuscripts generated from this study will be presented to peer-reviewed journals for publication. The full thesis submitted to my university of study may be accessed from the database of research managed by the University.

## 8.7 Conclusion

This research holds that parents of children involved in RTA in Ghana want constant access to their children in the hospital. They also want the opportunity to continue parenting in the hospital since it is believed to be in the best interest of the child and family. The health professionals, who consisted of mainly nurses, physicians and surgeons, believed in the principles of family involvement. They

perceived the concept of family involvement as helpful to the child and parents' emotional well-being, which in effect supported professionals in their caregiving roles.

Currently, there is no evidence of a policy on family involvement in the Ghanaian context and this was confirmed in the detailed literature reviewed for the writing of this final report. Thus, the finding of this study is deemed as new additions to knowledge in the Ghanaian socio-cultural context. Hence, it is anticipated that the specific recommendations that stemmed from this research if implemented will empower both the health professionals and patient families for the effective partnership in the care of child hospitalised through RTA.

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## 10 Appendices

### Appendix A: Participant information sheet for health professionals

**Title:** An exploration of perceptions on Family Centred Care (FCC) concept for trauma related hospitalised children in the Ghanaian context

#### Invitation



My name is Lillian Akorfa Ohene and I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you.

Please take time to read the following information carefully. You may wish to talk to others such as working colleagues and friends about the study before deciding whether to volunteer.

Please do ask me if there is anything that is not clear or if you would like more information (my contact details are at the end of this information sheet).

#### What is the purpose of the study?

The purpose of the study is to explore the perceptions of health professionals, parents and children on the concept of family centred care (FCC) in the context of a trauma related hospitalised children in Ghana. FCC is a concept that describes the essential roles parents play in the care of their sick children in hospital. It outlines roles such as the daily care parent (s) could give to the sick child whilst in hospital, the hospital support facilities available to parents, how parents may be involved in decision-making about their child care and not the least, what aspect of child care parents could negotiate for. Many countries have formally incorporated the FCC concept in care and continually researching ways to improve on its effectiveness. The general nursing education and the paediatric nursing training programme in Ghana teaches this concept in theory however, there is no research presently that has look at the concept in practice.

This research is being conducted as part of a PhD project at De Montfort University in Leicester. No one is paying me to do the research and I am solely responsible for the cost of my studies, which include my course fees, and the cost of conducting this research. The whole project aims to be completed by the end of 2016.

### **Why have I been invited to participate?**

You have been invited to take part in the study because you care for children involved in motor traffic trauma who are admitted to the child trauma and orthopaedic unit. I will also be inviting other health professionals, parents and children to participate in this study.

### **Do I have to take part?**

No, it is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect your employment status as a health professional or your relation with the hospital organisation you work for.

Once the interview is completed you will not be able to ask at a later date for the discussion to be withdrawn from the study.

### **What will happen to me if I take part?**

If you decide to take part you will be invited to be interviewed at a place that is most convenient to you. This could be in your own home or somewhere else you feel comfortable with such as a local restaurant or an office within the hospital.

I would like to record the discussions with a digital audio recorder if you give your permission. This will enable me to accurately record the things we discuss. I will also be able to go back over the recording to make sure I have noted down accurately what was said.

The interview will be as short or long as you wish however most interviews would take between 40 minutes to an hour. You may be asked if you would be willing to participate in a second interview if there are questions or topics that have not been covered in the first interview. You may be asked again if you would be willing to participate in focus group discussions to finalise the emerging themes from the whole study. However agreeing to participate in the first interview will not mean you have to participate in any other interviews for this project.

You may choose to have a colleague or friend with you while being interviewed if this helps you feel more comfortable.

### **What do I have to do?**

First of all you will be asked to sign a consent form of which you will be given a copy to keep. You will then be asked to discuss how hospital admitted motor traffic trauma children and their parents are managed at the unit you work.

### **What are the possible disadvantages and risks of taking part?**

Discussing what you may describe as challenging when giving care to a child involved in traffic trauma and the family could be upsetting. If you become upset or decide that you would rather stop the discussion, the interview will be ended immediately. You will also be provided with contacts details of individuals or organisations that may be able to provide counselling services.

### **What are the possible benefits of taking part?**

Participation in this study will bring no monetary benefit to you. Some people who have taken part in similar projects have said that it helps to have talked about a difficult time in their work experience.

The information that is generated from this study will be used to inform policy makers and may lead to the provision of support mechanisms to help health professionals to relate to parents as desired.

### **What if something goes wrong?**

It is unlikely that you will be harmed by taking part in this research. If you are harmed, by taking part in this research project, there are no compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

If you wish to complain, or have any concerns about any aspect of the way you have been approached you may have to contact your senior colleague of the unit or follow the outlined complain process of your organisation.

If you wish to complain about the way you were approached or treated in this study you may also contact the Head of School, Angela North-Rose, Head of School of Nursing and Midwifery, DE Montfort University, The Gateway Leicester. LE19BH. Telephone number is +44116213879.

### **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Your name and address will not be used in the research except for the purpose of contacting you, when you have agreed, to arrange an interview.

If you decide to have a colleague, friend, or relative present you should no longer assume complete confidentiality regarding the content of the interview.

If you mention something in the interview that indicates someone has acted wrongly I may need to inform someone else about it. I will wish to use your exact

words when I write up the study. However if you mention any other person by name I will change it so no one knows who you are talking about.

All recordings and any transcripts made from the recordings plus any notes made during and after the interview will be locked in a personal cabinet in my house. Files kept on a computer will be password protected. There will be no personal information on any of the transcripts or recordings.

Transcripts and recordings will be identified by code which will only be known to the researcher. This will be to enable follow up interview if agreed to and required. All recordings and transcripts will be kept for 5 years in accordance with the requirement of De Montfort University.

The research supervisors may examine the transcripts and recordings to check that the study is being carried out correctly.

### **What will happen to the results of the research study?**

The results from the study will be reported in a thesis and submitted for examination for a PhD. Results will also be used as part of one or more articles submitted for publication in professional journals and reporting at professional conferences. You will not be identifiable in any of these reports or publications.

### **Who is organising and funding the research?**

The research is organised by Lillian Ohene as part of her study for a PhD. I am not being paid to do this research. The research is being supervised within the normal supervision arrangements for PhD students within De Montfort University.

### **Who has reviewed the study?**

All research in hospitals in Ghana is looked at by independent group of people, called a research ethics committee to protect your safety, right, wellbeing and dignity. This study has been reviewed and given favourable opinion by Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB).

### **Contact for further information**

If you would like more information or would like to agree to be interviewed please contact Lillian Akorfa Ohene on 00233 208127700 (during office hours) or by

e-mail: [p12236904@myemail.dmu.ac.uk](mailto:p12236904@myemail.dmu.ac.uk) at

Lillian Akorfa Ohene

School of Nursing

University of Ghana

P.O. Box LG 43

Legon Accra

Alternatively you may return the reply slip accompanying this information sheet in the stamped addressed envelope. You may also contact the study supervisors, Professor Judith Tanner e mail [jtanner@dmu.ac.uk](mailto:jtanner@dmu.ac.uk) or Dr Kevin Power e mail [kpower@dmu.ac.uk](mailto:kpower@dmu.ac.uk) to learn more about the study.

**Please keep the rest of the information sheet for future reference.**

**Thank you for taking the time to read this information.**

## **Appendix B: Participant information sheet for parents**

**Title:** An exploration of perceptions on Family Centred Care (FCC) concept for trauma related hospitalised children in the Ghanaian context

### **Invitation**



My name is Lillian Akorfa Ohene and I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you.

Please take time to read the following information carefully. You may wish to talk to others such as family and friends about the study before deciding whether to volunteer.

Please do ask me if there is anything that is not clear or if you would like more information (my contact details are at the end of this information sheet).

### **What is the purpose of the study?**

The purpose of the study is to explore the perceptions of health professionals, parents and children on the concept of family centred care (FCC) in the context of a trauma related hospitalised children in Ghana. FCC is a concept that describes the essential roles parents play in the care of their sick children in hospital. It outlines roles such as the daily care parent (s) could give to the sick child whilst in hospital, the hospital support facilities available to parents, how parents may be involved in decision-making about their child care and not the least, what aspect of child care parents could negotiate for. Many countries have formally incorporated the FCC concept in care and continually researching ways to improve on its effectiveness. The general nursing education and the paediatric nursing training programme in Ghana teaches this concept in theory however, there is no research presently that has look at the concept in practice.

This research is being conducted as part of a PhD project at De Montfort University in Leicester. No one is paying me to do the research and I am solely responsible for the cost of my studies which include my course fees and the cost of conducting this research. The whole project aims to be completed by the end of 2016.



**Why have I been invited to participate?**

You have been invited to take part in the study because your child is/was admitted to the child trauma and orthopaedic unit. I will also be inviting other parents, children and health professionals to participate in this study.

**Do I have to take part?**

No it is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care your child receives now or in the future.

Once the interview is completed you will not be able to ask at a later date for the discussion to be withdrawn from the study.

**What will happen to me if I take part?**

If you decide to take part you will be invited to be interviewed at a place that is most convenient to you. This could be in your own home or somewhere else you feel comfortable with such as a local restaurant or an office within the hospital.

I would like to record the discussions with a digital audio recorder if you give your permission. This will enable me to accurately record the things we discuss. I will also be able to go back over the recording to make sure I have noted down accurately what was said.

The interview will be as short or long as you wish however most interviews would take between 40 minutes to an hour. You may be asked if you would be willing to participate in a second interview if there are questions or topics that have not been covered in the first interview. You may be asked again if you would be willing to participate in focus group discussions to finalise the emerging themes from the whole study. However agreeing to participate in the first interview will not mean you have to participate in any other interviews for this project.

You may choose to have a friend or partner with you while being interviewed if this helps you feel more comfortable. It is also possible to interview both parents at the same where this is desired by a couple. It is also possible to interview you as a family with your child present if you wish it.

**What do I have to do?**

First of all you will be asked to sign a consent form of which you will be given a copy to keep. You will then be asked to discuss you and your child's admission to the trauma and orthopaedic unit.

If your child is old enough you may be asked if your child can be approached for their consent to be interviewed as part of this project. If you do agree for your child to be approached they will be given an information sheet and the same free choice to decide for themselves if they wish to be interviewed or not.

If your child is under 16 and consent to be interviewed you will also be asked to sign a consent form agreeing to them being interviewed. This is not because your child cannot be trusted to make their own mind up but because I will be required to gain your consent by the authorities approving the study.

You need to be aware that unless your child gives me permission (or your child agrees to you present) I will not be able to tell you anything that your child has said in the interview or show you any transcripts of the conversation.

Your child will be given free choice of venue for the interview. This might be in your own home or a public place such as a local restaurant or an office within the hospital. In either case if the child does not consent to you being present you will be nearby but out of hearing.

Your child will also be given the opportunity to have a friend or brother/sister with them while they are being interviewed if they wish.

### **What are the possible disadvantages and risks of taking part?**

Discussing the time when your child was involved in the motor traffic trauma and in a critical condition could be upsetting. If you become upset or decide that you would rather stop the discussion, the interview will be ended immediately. You will also be provided with contacts details of individuals or organisations that may be able to provide counselling services.

### **What are the possible benefits of taking part?**

### **What if something goes wrong?**

It is unlikely that you and your child will be harmed by taking part in this research. If you are harmed by taking part in this research project, there are no compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the hospitals'

complaints mechanisms should be available to you. You may also contact the head nurse in-charge of the unit. Monday to Friday 8am until 5pm

Telephone:

Text & Mobile:

Email:

Office:

Letter:

If you wish to complain about the way you were approached or treated in this study you may also contact the Head of School, Angela North-Rose, Head of School of Nursing and Midwifery, DE Montfort University, The Gateway Leicester. LE19BH. Telephone number is +44116213879.

### **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Your name and address will not be used in the research except for the purpose of contacting you, when you have agreed, to arrange an interview.

If you decide to have a spouse, friend or relative present you should no longer assume complete confidentiality regarding the content of the interview.

If you mention something in the interview that indicates someone has acted wrongly I may need to inform someone else about it. I will wish to use your exact words when I write up the study. However if you mention any other person by name I will change it so no one knows who you are talking about.

All recordings and any transcripts made from the recordings plus any notes made during and after the interview will be locked in a personal cabinet in my house. Files kept on a computer will be password protected. There will be no personal information on any of the transcripts or recordings.

Transcripts and recordings will be identified by code which will only be known to the researcher. This will be to enable follow up interview if agreed to and required. All recordings and transcripts will be kept for 5 years in accordance with the requirement of De Montfort University.

The research supervisors may examine the transcripts and recordings to check that the study is being carried out correctly.

### **What will happen to the results of the research study?**

The results from the study will be reported in a thesis and submitted for examination for a PhD. Results will also be used as part of one or more articles submitted for publication in professional journals and reporting at professional conferences. You will not be identifiable in any of these reports or publications.

### **Who is organising and funding the research?**

The research is organised by Lillian Ohene as part of her study for a PhD. I am not being paid to do this research. The research is being supervised within the normal supervision arrangements for PhD students within De Montfort University.

### **Who has reviewed the study?**

All research in hospitals in Ghana is looked at by independent group of people, called a research ethics committee to protect your safety, right, wellbeing and dignity. This study has been reviewed and given favourable opinion by Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB).

### **Contact for further information**

If you would like more information or would like to agree to be interviewed please contact Lillian Akorfa Ohene on 00233 208127700 (during office hours) or by e-mail

[p12236904@myemail.dmu.ac.uk](mailto:p12236904@myemail.dmu.ac.uk)

Lillian AkorfaOhene

School of Nursing

University of Ghana

P.O. Box LG 43

Legon Accra

Alternatively you may return the reply slip accompanying this information sheet in the stamped addressed envelope. You may also contact the study supervisors, Professor Judith Tanner e mail [jtanner@dmu.ac.uk](mailto:jtanner@dmu.ac.uk) or Dr Kevin Power e mail [kpower@dmu.ac.uk](mailto:kpower@dmu.ac.uk) to learn more about the study.

**Please keep the rest of the information sheet for future reference.**

**Thank you for taking the time to read this information.**

## **Appendix C: Participant information sheet for patients 16 years over**

(This document is developed in consultation with children in Ghana)

**Title** An exploration of perceptions on family centred care concept for trauma related hospitalised children in the Ghanaian context

### **Invitation**



My name is Lillian Akorfa Ohene and I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you.

Please take time to read the following information carefully. You may wish to talk to others such as family and friends about the study before deciding whether to volunteer.

Please do ask me if there is anything that is not clear or if you would like more information (my contact details are at the end of this information sheet).

### **What is the purpose of the study?**

The reason I am doing this study is to find out the different views on the way children admitted in hospital and their families should be cared for. Children and family care in hospital could be in the form of allowing parents or other family members to be present with the admitted child constantly in the hospital, with or without performing any duties for the sick child. Another option may also be given to the child and parents to decide what they want to do and how the doctors and nurses could be of help. These different options given the sick child and family are termed family centred care.

The general nursing education and the paediatric nursing training programme in Ghana teaches this concept in theory however, there is no research presently that has look at the concept in practice.

This research is being conducted as part of a PhD project at De Montfort University in Leicester. No one is providing separate funding for the project. I am a student and am not employed by the hospital where you were cared for.

The whole project aims to be completed by the end of 2016.

### **Why have I been invited to participate?**

You have been invited to take part in the study because you have spent some time in the child accident and trauma unit. I will also be inviting other children, parents and health professionals to participate in this study.

### **Do I have to take part?**

No, it is entirely up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive now or in the future.

### **What will happen to me if I take part?**

If you decide to take part you will be invited to be interviewed at a place that is most convenient to you. This could be in your own home or somewhere else you feel comfortable with such as a local restaurant or an office within the hospital.

I would like to record the discussions with a digital audio recorder if you give your permission.

This will enable me to accurately record the things we discuss. I will also be able to go back over the recording to make sure I have noted down accurately what was said.

The interview will be as short or long as you wish however most interviews would take between 40 minutes to an hour. You may be asked if you would be willing to participate in a second interview if there are questions or topics that have not been covered in the first interview. Agreeing to participate in the first interview will not mean you have to participate in any other interviews for this project.

You may choose to have a friend, brother/sister or parent with you while being interviewed if this helps you feel more comfortable. It is also possible to interview you as part of a family if you so wish.

### **What do I have to do?**

First of all you will be asked to sign a consent form of which you will be given a copy to keep.

You will be asked to discuss as freely and honestly your views on how you and your family should be cared for in hospital while you were on admission to the accident and trauma unit.

### **What are the possible disadvantages and risks of taking part?**

Discussing the time when you were involved in traffic trauma and in a critical condition could be distressing. If you become upset or decide that you would rather stop the discussion, the interview will be ended immediately. You will also be provided with contacts details of individuals or organisations that may be able to provide counselling services.

### **What are the possible benefits of taking part?**

Participation in this study will bring no health benefit to you. Some people who have taken part in similar kinds of projects have said that it helps to have talked about a difficult time in their life

The information that is generated from this study will be used to inform health professionals.

### **What if something goes wrong?**

It is unlikely that you will be harmed by taking part in this research. If you are harmed, by taking part in this research project, there are no compensation arrangements. If you are harmed because someone involved in the study does something wrong that causes you harm (called negligence), you may have grounds for a legal action but you may have to pay for it.

If you have any concerns about the way you have been treated in this study, the normal hospitals' complaints mechanisms should be available to you.

You may also contact the head nurse in-charge of the unit. Monday to Friday 8a.m until 5p.m

Telephone:

Text & Mobile:

Email:

Office:

Letter:

If you wish to complain about the way you were approached or treated in this study you may also contact the Head of School, Angela North-Rose, Head of School of Nursing and Midwifery, DE Montfort University, The Gateway Leicester. LE19BH. Telephone number is +44116213879.

### **Will my taking part in this study be kept confidential?**

All information which is collected from you during the course of the research will be kept strictly confidential. Your name and address will not be used in the

research except for the purpose of contacting you, when you have agreed, to arrange an interview.

If you decide to have a friend or relative present you should no longer assume complete confidentiality regarding the content of the interview.

If you mention something in the interview that indicates someone has acted wrongly I may need to inform someone else about it.

All recordings and any transcripts made from the tape will be locked in a personal cabinet in my house. The same is true for any notes made during and after the interview. Files kept on a computer will be password protected.

There will be no personal information on any of the transcripts or recordings.

Transcripts and recordings will be identified by code which will only be known to the researcher. This will be to enable follow up interview if agreed to and required. Codes linking personal details to transcripts and tapes will be kept in a separate password protected file.

All recordings and transcripts will be kept for 5 years in accordance with the requirements of De Montfort University.

The research supervisors may examine the transcripts and recordings to check that the study is being carried out correctly.

### **What will happen to the results of the research study?**

The results from the study will be reported in a write up called a thesis and submitted for examination for a PhD. Results will also be used as part of articles submitted for publication in professional magazines and reporting at professional conferences. No one will be able to tell who you are in any of these reports or publications.

### **Who is organising and funding the research?**

The research is organised by Lillian Ohene as part of her study for a PhD. I am not being paid to do this research. The research is being supervised within the normal supervision arrangements for PhD students within De Montfort University.

### **Who has reviewed the study?**

All research in hospitals in Ghana is looked at by independent group of people, called a research ethics committee to protect your safety, right, wellbeing and dignity. This study has been reviewed and given favourable opinion by Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB).



**Contact for further information**

If you would like more information or would like to agree to be interviewed please contact Lillian Akorfa Ohene on 00233 208127700 (during office hours) or by e mail

[p12236904@myemail.dmu.ac.uk](mailto:p12236904@myemail.dmu.ac.uk) at

Lillian Akorfa Ohene

School of Nursing

University of Ghana

P.O. Box LG 43

Legon Accra

Alternatively you may return the reply slip accompanying this information sheet in the stamped addressed envelope that came with this information sheet. You may also contact the study supervisors, Professor Judith Tanner e mail [jtanner@dmu.ac.uk](mailto:jtanner@dmu.ac.uk) or Dr Kevin Power e mail [kpower@dmu.ac.uk](mailto:kpower@dmu.ac.uk) to learn more about the study.

**Please keep the rest of the information sheet for future reference.**

**Thank you for taking the time to read this information.**

## **Appendix D: Participant information sheet for patients 11-15 years**

**(This document is developed in consultation with children in Ghana)**

**Title:** An exploration of perceptions on family centred care concept for trauma related hospitalised children in the Ghanaian context

### **Invitation**



My name is Lillian Akorfa Ohene, I am a student learning about family, and children care in hospital. I am studying at a University in the United Kingdom called De Montfort University, Leicester.

I would like to invite you to take part in a research study. I am interested in finding out views on the way parents may be involved in their children's care in the hospital. Different ways of involving parents and families in the care of the sick child can be called family centred care.

Before you decide if you want to join in it is important to understand why the study is being done and what it would involve for you. So please read this leaflet carefully. Talk about it with your family, friends and doctors or nurse if you want to.

Take time to decide whether or not you would like to take part.

If you would like to have more information please get in touch by phone or e mail. I have put the phone number and e mail address at the end of this sheet

### **Why am I doing this study?**

The reason I am doing this study is to try and understand how sick children, parents and families are cared for in the hospital. This can be in a form of allowing one of your parents or another family member to stay with you in hospital and do things you want them to do for you. Sometimes your parents may also ask to go home and come around sometimes in the day.

There are different ways of going about parents, families and their children care in hospital. Nurses learn this during training and it will be interesting to know how good or bad it is to apply what they learn in practice.

So far no studies of this kind have been done in children's accident ward in Ghana.





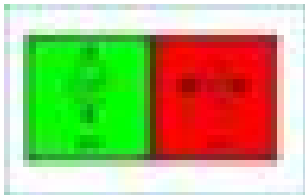
This research is being done as part of a PhD project (a university degree). No one is paying me to do this project. I am a student at De Montfort University in Leicester. I am not employed by the hospital where you were cared for.

The whole project should be completed by the end of 2016. This seems a long time but is not unusual for this type of project.

### **Why have I been invited to participate?**

You have been invited to take part in the study because you have spent some time in the children trauma and orthopaedic ward. You, your parents and other members of your family may have ideas about how things should be done for you. I will also be inviting other children, parents and nurses to take part in this study.

### **Do I have to take part?**



No it is up to you to decide whether or not to take part. If you decide to take part you will be given an information sheet to keep. You will also be asked to sign a form saying you agree to have a discussion with me. I will also have to ask one of your parents to sign a form as well.

This is not because you are not trusted to decide for yourself. I have to get an adult's signature because I have been asked to by the people who gave me permission to do the study.

You are free to stop taking part at any time during the discussion without giving a reason. If you decide to stop, this will not affect the care you receive now or in the future.



### **What will happen to me if I take part?**

If you decide to take part you will be invited to have a discussion with me at a place that suits you. This could be in your own home or somewhere else you feel happy with such as a local restaurant or an office within the hospital. I will ask you if I can record our discussion about your hospital admission. This will help me make sure I do not miss anything out.



The discussion can be as short or long as you wish. Most discussions would take between 40 minutes. You may be asked if it would be okay to take part in a second discussion.

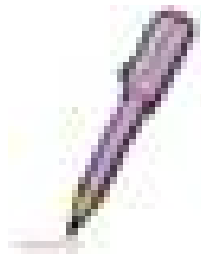
A second discussion might be useful if I need to check out something you have said or ask some more questions about something we have talked about.

Taking part in the first discussion does not mean you have to take part in any other discussions for this study if you do not want to.

You may choose to have a friend or brother or sister or parent with you while we talk if you like. It is also possible to talk to you at the same time as your parents if you would like to have the discussion as a family.



### **What do I have to do?**



First of all you will be asked to sign a form to say you are happy to discuss your time in the accident ward with me. You will be given a copy of the form to keep.



You will be asked to discuss how you want your parents and family to get involved in your care in the accident ward.

### **What are the possible disadvantages and risks of taking part?**

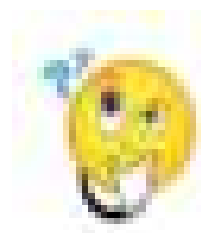
Discussing the time when you wish to see or to have your parents or other family members to do something for you and they were not there could be upsetting. If you become upset tell me that you would rather stop, the discussion will be ended straight away.

### **What are the possible benefits of taking part?**

Taking part will not improve your health. Some young people that have taken part in similar studies have said that it helps to have a talk about a difficult time in their life.

The information from this study will be used to inform doctors and nurses. The information may lead to changes in the way parents and family members of sick children in hospital are involved in their child care.

### **What if something goes wrong?**



It is not likely that you will be harmed by taking part in this project. If you are harmed, by taking part in this research project, there are no compensation arrangements.

If you have any concerns about the way you have been treated in this study you may contact the patient advice and complain unit in the hospital. They are open Monday to Friday 8a.m until 5p.m

Telephone:

Text & Mobile:

Email:

Office:

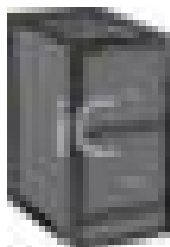
Letter:

If you wish to complain about the study you may also contact the Head of School, Angela North-Rose, Head of School of Nursing and Midwifery, DE Montfort University, The Gateway Leicester. LE19BH. Telephone number is +44116213879.

### **Will my taking part in this study be kept private?**

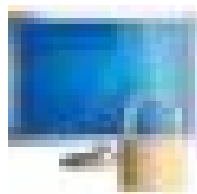
All information which is collected will be kept private. Your name and address will not be used in the study. If you decide to have a friend or your parent(s) there please remember that they will know what you have said.

I will not tell your parents what you have said unless you tell me I can. I will not show your parents anything I write down from our discussion unless you tell me I can.



If you tell me about something that somebody has done that was wrong I may need to tell someone else about it.

All recordings and copies of what was said in the discussion and written down (called a transcript) will be kept locked up in a personal cabinet in my house. Any notes made during and after the interview will also be locked away.



Files kept on a computer will have a password so no one else can read them.

I will need to use your exact words when I write about the study. If you mention another person's name I will change it so no one knows who you are talking about.

My research supervisors may look at the notes and recordings. A person from the hospital may also inspect them. This is to check that the study is being carried out properly. Your name or address will not be on any of the typed out copies or recordings.



### **What will happen to the results of the study?**

The results from the study will be submitted for an exam for a PhD. Results will also be sent to a magazine so other people can read what I have found out. I may also speak about the study at conferences. No one will know who you are in any of these reports or publications.



### **Who is organising and funding the research?**

The research is being done by Lillian Akorfa Ohene as part of her study for a PhD. No one is paying me for this research.

### **Contact for further information**

If you would like more information or would like to agree to be interviewed please contact Lillian Akorfa Ohene on 00233 208127700 (during office hours) or by e mail [p12236904@myemail.dmu.ac.uk](mailto:p12236904@myemail.dmu.ac.uk) or by mail at

Lillian Akorfa Ohene

School of Nursing

University of Ghana

P.O. Box LG 43

Legon Accra

If you prefer, you may return the reply slip in the stamped addressed envelope that came with this information sheet. You may also contact the study supervisors, Professor Judith Tanner e mail [jtanner@dmu.ac.uk](mailto:jtanner@dmu.ac.uk) or Dr Kevin Power e mail [kpower@dmu.ac.uk](mailto:kpower@dmu.ac.uk) to learn more about the study.

**Please keep the rest of the information sheet for future reference.**

**Thank you for taking the time to read this information sheet.**

## **Appendix E: Participant information sheet patient 8-10 years**

**(This document is developed in consultation with children in Ghana)**

**Title:** An exploration of perceptions on family centred care concept for trauma related hospitalised children in the Ghanaian context.

### **Invitation**



My name is Lillian Akorfa Ohene and I am student learning about children care in hospital. My University is in United Kingdom.

I would like to invite you to take part in a research study. I am interested in finding out, how parents are involved in their children care in hospital.

Before you decide if you want to join in it is important to understand why the study is being done and what it would involve for you. So please read these papers carefully. Talk about it with your family,

friends, doctors or nurse if you want to.

Take time to decide whether or not you would like to take part. If you would like to have more information please get in touch by calling or writing me a text on phone. I have put the phone number at the end of this sheet



### **Why am I doing this study?**

I am doing this study to try and understand how sick children, parents and families are cared for in the hospital. Nurses learn this during training and it is important to know how good or bad it will be in practice.



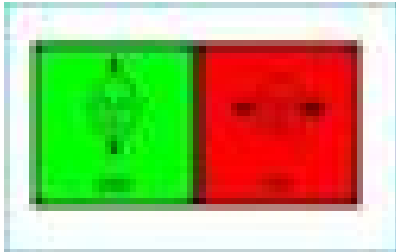
No one is paying me to do this project. I am doing it as a student because it is part of what I learn in my University. I do not work for the hospital where you were cared for.

The whole project should be completed by the end of 2016. This seems a long time but is not strange for this type of project.

### **Why have I been invited to take part?**

You have been invited to take part in the study because you have spent some time in the hospital ward where children involved in car accidents are cared for. I will also be inviting other children, parents and nurses to take part in this study.

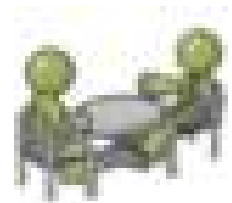
### **Do I have to take part?**



No, it is up to you to decide whether or not to take part. If you decide to take part you will be given these papers to keep.

You will also be asked to sign a form saying you agree to have a discussion with me.

I will also have to ask one of your parents to sign a form as well. This is not because you are not trusted to make your own decisions. I have to get an adult's signature because I have been asked to by the people who gave me permission to do the study.



You are free to stop taking part at any time during the discussion without saying why. If you decide to stop no one will be angry with you.



### **What will happen to me if I take part?**



If you decide to take part you will be invited to have a discussion with me at a place that suits you. This could be in your own home or somewhere else you feel happy with such as a local restaurant or an office within the hospital.

I will ask you if I can record our discussion about your hospital admission. This will help me make sure I do not miss anything out.

The discussion can be as short or long as you wish. Most discussions would take between 30 minutes or as long as a children's TV programme.

You might be asked if it would be okay to take part in a second discussion.

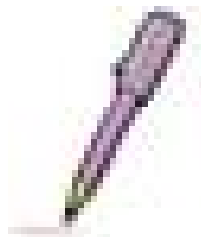
Taking part in the first discussion does not mean you have to take part in any other discussions for this study if you do not want to.

You may choose to have a friend or brother or sister or parent with you while having the discussions if you like. It is also possible to do the discussion with you



at the same time as your parents if you would like to have the discussion as a family.

### **What do I have to do?**



First of all you will be asked to sign a form to say you are happy to discuss your time in hospital ward with me. You will then be given a copy of the form to keep.

You will be asked to discuss how you want your parents and family to get involved in your care in the hospital ward.

### **What are the possible difficulties and dangers of taking part?**



Discussing the time when you wish to see or to have your parents or other family members to do something for you and they were not there could be upsetting. If you become upset tell me that you would rather stop, the discussion will be ended straight away.

### **What are the possible gains of taking part?**

Taking part in this study will not improve your health. Some young people that have taken part in studies like this type have said that it helps to have a talk about a difficult time in their life.

The information from this study will be used to inform doctors and nurses. The information may lead to changes in the way parents and family members of sick children in hospital are involved in their child care.

### **What if something goes wrong?**



If you are not happy about the way you have been treated in this study you may ask your parents to contact the patient advice and complain unit in the hospital. They are open Monday to Friday 8am until 5pm

Telephone:

Text & Mobile:

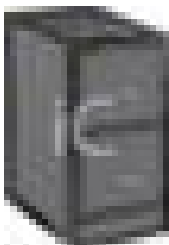
Email:

Office:

Letter:

If you wish to complain about the study you may also contact the Head of School, Angela North-Rose, Head of School of Nursing and Midwifery, DE Montfort University, The Gateway Leicester. LE19BH. Telephone number is +44116213879.

### **Will my taking part in this study be kept private?**



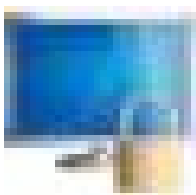
All information which is collected will be kept private. Your name and address will not be used in the study

I will not tell your parents what you have said unless you tell me I can.

If you tell me about something that somebody has done that was wrong I may need to tell someone else about it.



All recordings and copies of what was said in the discussion and written down will be kept locked up in a personal cupboard in my house.



Typed work from our discussions kept on a computer will be locked so no one else can read them.

I will need to use your exact words when I write about the study. If you mention another person's name I will change it so no one knows who you are talking about.



### **What will happen to the results of the study?**

I will be writing a very long story about my discussions with you and other children. Teachers at the university will give me marks for this story.

Part of the story will also be sent to a magazine so other people can read what I have found. No one will know who you are in these stories.



### **If you want to know more**

If you would like to know more or would like to agree to talk to me please ask your parents to contact me on 00233 208127700 (during office hours) or by post at this address.

Lillian Akorfa Ohene

School of Nursing

University of Ghana

P.O. Box LG 43

Legon Accra

If you prefer you may return the reply slip in the stamped addressed envelope that came with this information sheet. You may also contact the study supervisors, Professor Judith Tanner e mail [jtanner@dmu.ac.uk](mailto:jtanner@dmu.ac.uk) or Dr Kevin Power e mail [kpower@dmu.ac.uk](mailto:kpower@dmu.ac.uk) to learn more about the study.

**Please keep the rest of the papers for future use.**

**Thank you for taking the time to read these papers.**

## Appendix F: Letter of acceptance to participate in the research

Dear Lillian,

I am interested in taking part in the family and children care study and would be happy to be contacted in order to have a discussion with you.

Name(s) .....  
.....

I/we can be contacted;

By Phone Tel .....

By Post: .....  
.....  
.....  
.....  
.....

Please note writing out and returning of this form does not mean you have given permission to have a discussion. Return of this form does not force you to have the discussion.

A separate form called consent form will be available for signing before the interview takes place.

## Appendix G: Consent form for health professionals



### Participant Identification Code for this study:

**Title of Project: An exploration of perceptions on Family Centred Care concept for trauma related hospitalised children in the Ghanaian context**

**Name of Researcher: Lillian Akorfa OHENE**

Issue	Respondent's initial
I confirm that I have read and understand the information sheet dated 30/08/2013(version 1.0) for the above study.	
I have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.	
I consent to anonymous quotes from my interview (s) to be included in any publications arising from this research study.	
I give permission for the interview to be recorded using audio recording equipment.	
I understand that relevant sections of the data collected during the study may be looked at by individuals from De Montfort University and regulatory authorities (example Institutional Review Board of Noguchi Memorial Institute for Medical Research), where it is	

relevant to my taking part in this research. I give permission for these individuals to have access to my responses.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected or my employer being informed.	
I agree to take part in the individual interview.	
I agree to take part in follow up interview and the focus group discussion which confirms the emerging themes from the study.	

Participant Name:		Consent taken by	
Participant Signature:		Signature	
Date		Date	

When completed, 1 for participant; 1 for researcher file.

## Appendix H: Consent form for parents



**Participant Identification Code for this study:**

**Title of Project: An exploration of perceptions on Family Centred Care concept for trauma related hospitalised children in the Ghanaian context**

**Name of Researcher: Lillian Akorfa OHENE**

<b>Issue</b>	<b>Respondent's initial</b>
I have had information read and explained to me and understood the information sheet dated 30/08/2013 (version 1.0) for the above study.	
I have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.	
I consent to anonymous quotes from my interview (s) to be included in any publications arising from this research study.	
I give permission for the interview to be recorded using audio recording equipment.	
I understand that relevant sections of the data collected during the study may be looked at by individuals from De Montfort University and regulatory authorities (example Institutional Review Board of	

Noguchi Memorial Institute for Medical Research), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my responses.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my child's medical or my legal rights being affected.	
I give permission for the researcher to approach my child for his/her consent to take part in the study.	
I agree to take part in the individual interview.	
I agree to take part in any other follow up interview and the focus group discussion which confirms the emerging themes from the study.	

Participant Name:		Consent taken by	
Participant Signature:		Signature	
Date		Date	

When completed, 1 for participant; 1 for researcher file.



## Appendix I: Assent form for patients 16+



### Participant Identification Code for this study:

**Title of Project: An exploration of perceptions on Family Centred Care concept for trauma related hospitalised children in the Ghanaian context**

**Name of Researcher: Lillian Akorfa OHENE**

Issue	Respondent's initial
I have had information read and explained to me and understood the information sheet dated 06/09/2013 (version 2.0) for the above study.	
I have had the opportunity to consider the information, ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
I understand that anonymous direct quotes from my interview (s) may be used in any published report and/or conference presentations.	
I give permission for the interview to be recorded using audio recording equipment.	

I understand that sections of the data collected during the study may be looked at by individuals from De Montfort University and regulatory authorities (example Institutional Review Board of Noguchi Memorial Institute for Medical Research or Ghana health service), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my responses.	
I agree to take part in the study	

Participant Name:		Consent taken by	
Participant Signature:		Signature	
Date		Date	

When completed, 1 for participant; 1 for researcher file.

## Appendix J: Assent form for patients under 16 years



### Participant Identification Code for this study:

(This document is developed in conjunction with children in Ghana)

**Title of Project: An exploration of perceptions on Family Centred Care concept for trauma related hospitalised children in the Ghanaian context**

**Name of Researcher: Lillian Akorfa OHENE**

Issue	Respondent's initial
I have had information read and explained to me and understood the information papers dated 06/09/2013 (version 2.0) for the above study.	
I have had the chance to think about what is written on the papers, ask any questions I have and had them answered.	
I understand that I can stop at any time without giving any reason, without my medical care or legal rights being affected.	
I understand that my words from the discussion may be used in published reports and/or conference presentations.	
I give permission for the interview to be recorded using audio recording equipment.	
I understand that parts of what I say in the interview may be looked at by staff from De Montfort University and regulatory authorities	

(example Institutional Review Board of Noguchi Memorial Institute for Medical Research), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my responses.	
I agree to take part in the above study	

Participant Name:		Consent taken by	
Participant Signature or thumb print:		Signature	
Date		Date	

When completed, 1 for participant; 1 for researcher file.

## Appendix K: Letter of introduction from the research supervisor



26/11/2013

The Deputy Director/Officer In-Charge of Nursing Services,  
37 Military Hospital  
Accra, Ghana

Dear Sir/Madam,

### LETTER OF INTRODUCTION-LILLIAN AKORFA OHENE

I would like to introduce to you the above named Doctoral Student of School of Nursing, Faculty of Health and Life Sciences, De Montfort University, Leicester UK. She is also an Assistant Lecturer of University of Ghana, Legon and a specialist paediatric nurse.

Lillian is at the stage of collecting data for her research. Her working topic is "An exploration of perceptions of family centred care concept for trauma related hospitalized children in the Ghanaian context"; and she will be working with children on hospital admission through trauma, and their caregivers.

I can confirm that Lillian has followed due procedures as stipulated in the postgraduate research regulations and has been given ethical approval for the study by this University (See attached copies of ethics approval and all other necessary documents of the study).

As the Professor of Clinical Nursing Research, School of Nursing, De Montfort University, Leicester, and also in the capacity as her first supervisor, I kindly request your assistance and support to enable her collect data in your facility. Do not hesitate to contact me for any further clarifications.

Thank you.

Yours faithfully,

A handwritten signature in blue ink that reads "Judith Anne Tanner".

Professor Judith Tanner  
Chair of Clinical Nursing Research  
De Montfort University  
3.36 Edith Murphy House  
The Gateway  
Leicester  
LE1 9BH

26/11/2013

Dear Sir/Madam,

**LETTER OF INTRODUCTION-LILLIAN AKOFEA OHENE**

I would like to introduce to you the above named Doctoral Student of School of Nursing, Faculty of Health and Life Sciences, De Montfort University, Leicester UK. She is also an Assistant Lecturer of University of Ghana, Legon and a specialist paediatric nurse.

Lillian is at the stage of collecting data for her research. Her working topic is "An exploration of perceptions of family centred care concept for trauma related hospitalised children in the Ghanaian context"; and she will be working with children on hospital admission through trauma, and their caregivers.

I can confirm that Lillian has followed due procedures as stipulated in the postgraduate research regulations and has been given ethical approval for the study by this University (See attached copies of ethics approval and all other necessary documents of the study).

As the Professor of Clinical Nursing Research, School of Nursing, De Montfort University, Leicester, and also in the capacity as her first supervisor, I kindly request your assistance and support to enable her collect data in your facility. Do not hesitate to contact me for any further clarifications.



Thank you.

Yours faithfully,



Professor Judith Tanner  
Chair of Clinical Nursing Research  
De Montfort University  
3.36 Edith Murphy House  
The Gateway  
Leicester  
LE1 9BH  
0115 2013885  
jtanner@dmu.ac.uk

**Appendix L: Letter of introduction from the director of nursing services to wards**

<p><small>In case of reply the number And the date of this Letter should be quoted</small></p> <p><small>My Ref. No. _____ Your Ref. _____</small></p>		<p><b>KORLE BU TEACHING HOSPITAL</b></p> <p><small>P.O. BOX KB 77 KORLE BU, ACCRA Tel: 233 – 302-673034-6 Fax: 233 – 302-667759 Email: <a href="mailto:pr@kbbh.gov.gh">pr@kbbh.gov.gh</a> <a href="mailto:pr@kbbh.gov.gh">pr@kbbh.gov.gh</a> Website: <a href="http://www.kbbh.gov.gh">www.kbbh.gov.gh</a></small></p>
<p><b>NURSING DIRECTORATE</b></p>		
<hr/>		
<p><b>M E M O</b></p>		
<p>FROM: DIRECTOR OF NURSING SERVICES </p>		
<p>TO: HOD / DDNS, TRAUMA / WARD I</p>		
<p>DATE: 28<sup>TH</sup> JANUARY, 2014</p>		
<p>SUBJECT: <b>PERMISSION TO CONDUCT RESEARCH</b></p>		
<p>.....</p>		
<p>Ms Lilian Akorfa Ohene, a Doctoral Student of the school of Nursing, DeMontfort University, Leicester UK.</p>		
<p>Research topic "An exploration of perceptions of family centred care concept for trauma related hospitalised children in the Ghanaian context".</p>		
<p>Your assistance will be very much appreciated.</p>		
<p>Find attached a copy of her permission letter and research proposal.</p>		
<p>Thank you.</p>		

To copy of reply to be made  
And the date of the  
Letter should be noted:

My Ref No. \_\_\_\_\_  
Your Ref. \_\_\_\_\_



KORLEBU TEACHING HOSPITAL

P.O. BOX 4877  
KORLEBU, ACCRA  
Tel: 333 - 302 6730/31-4  
Fax: 333 - 302 4677/39  
Email: [pr@kbtgh.gov.gh](mailto:pr@kbtgh.gov.gh)  
[pr@kbtgh.gov.gh](mailto:pr@kbtgh.gov.gh)  
Website: [www.kbtgh.gov.gh](http://www.kbtgh.gov.gh)

NURSING DIRECTORATE

**M E M O**

FROM: DIRECTOR OF NURSING SERVICES 

TO: HOD / DDNS, TRAUMA / WARD I

DATE: 28<sup>TH</sup> JANUARY, 2014

SUBJECT: **PERMISSION TO CONDUCT RESEARCH**

Ms Lillian Aforfa Oshene, a Doctoral Student of the school of Nursing, DeMontfort University, Leicester UK.

Research topic "An exploration of perceptions of family centred care concept for trauma related hospitalised children in the Ghanaian context".

Your assistance will be very much appreciated.

Find attached a copy of her permission letter and research proposal.

Thank you.

0266183282-Lillian

22.01.15

Permission granted.

The student should contact the  
DDNS for assistance.



## **Appendix M: Notice to staff and the public**

### **Information about Family Centred Care (FCC) study**

I am a paediatric nurse assistant lecturer at School of Nursing University of Ghana, Legon. I am currently undertaking a PhD research study on perceptions of Family Centred Care (FCC) for motor traffic trauma hospitalised children in Ghana. The FCC project is not funded by any external agency.

#### **Aim:**

The aim of this study is to explore the perceptions of health professionals, parents and children on FCC as a care model for trauma related hospitalized children in Ghana.

#### **Sample:**

Health professionals mainly nurses, parents and where appropriate, family relations directly in charge of hospitalised child care, and children.

Sample size will be determined by data saturation, however, it is anticipated that 15-20 health professionals and 15 parents will participate in individual interviews and focus group discussions, and 15 children will participate in individual interviews only.

#### **Data collection methods:**

Individual interviews will be done and audio recorded. Interviews will be granted to parents and children who wish to be interviewed as a family. Interviews will take place at participants' location of choice. Data collection is anticipated to begin in the first quarter of 2014. Some participants may be contacted later in the year 2014 for follow up focus group discussions on the emerging themes from the interviews.

#### **Data analysis:**

Audio recorded interviews transcribed will be analysed according to the grounded theory method (Strauss and Corbin 1998) and participants' engagement in analysis (Charmaz 2006); through focus group discussions to verify emerging themes.

#### **Dissemination:**

The findings of study will be submitted to and examined by De Montfort University leading to the award of a PhD. Findings will also be presented at conferences both local and international, and in professional journals.

Ethical issues regarding the study were reviewed and approved by the ethics committee of Faculty of Health and Life Sciences, De Montfort University and Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB).

Lillian Akorfa Ohene  
School of Nursing  
University of Ghana  
P.O. Box LG 43  
Legon Accra  
[p12236904@myemail.dmu.ac.uk](mailto:p12236904@myemail.dmu.ac.uk)

## Appendix N: Ethical approvals (1 to 3)



HLS FREC Ref: 1202

28<sup>th</sup> November 2013

Lillian Akorfa Ohene  
Millstone Court  
Flat 9, Room 1  
26 – 30 Millstone Lane  
Leicester  
LE1 5JN

Dear Lillian

**Re: Ethics application – An exploration of Perceptions on Family Centred Care Concept for Trauma Related Hospitalised Children in the Ghanaian Context (dmu ref: 1202)**

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by Chair's Action for your application. This will be reported at the next Faculty Research Committee, which is being held on 30<sup>th</sup> January 2014.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee.

The Faculty Research Ethics Committee should be notified by e-mail to [HLSFRO@dmu.ac.uk](mailto:HLSFRO@dmu.ac.uk) when your research project has been completed.

Yours sincerely,

A handwritten signature in blue ink that reads "M. Grootveld".

Professor Martin Grootveld  
Chair  
Faculty of Health and Life Sciences  
Research Ethics Committee

# NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH

Established 1979

A Constituent of the College of Health Sciences

University of Ghana

Phone: +233-302-416418 (Dinner)  
+233-289-522174  
Fax: +233-302-502182/513282  
E-mail: [nifs@noguchi.orinmimr.org](mailto:nifs@noguchi.orinmimr.org)  
Telex No. 2556 LGL, GH

## INSTITUTIONAL REVIEW BOARD



Post Office Box LG 581  
Legon, Accra  
Ghana

My Ref. No. DR 22  
Your Ref. No.

8<sup>th</sup> January, 2014

## ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 061/13-14

IORG 0000908

On 8<sup>th</sup> January 2014, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

**TITLE OF PROTOCOL** : An exploration of perceptions on family centred care concept for trauma related hospitalised children in the Ghanaian context

**PRINCIPAL INVESTIGATOR** : Lillian Akorfa Ohene, PhD Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 7<sup>th</sup> January, 2015. You are to submit annual reports for continuing review.

Signature of Chair:   
Mrs. Chris Dadzie  
(NMIMR – IRB, Chair)

cc: Professor Kwadwo Koram  
Director, Noguchi Memorial Institute  
for Medical Research, University of Ghana, Legon



**Institutional Review Board**

37 Military Hospital

Neghelli Barracks

ACCRA

Tel: 0302-775958

Email: [irb37milhosp@hotmail.com](mailto:irb37milhosp@hotmail.com)

31 March 2014

**Our Ref: IRB/37MH/062/14**

**ETHICAL CLEARANCE**

**37MH-IRB IPN 003/2014**

On 18<sup>th</sup> February 2014 the 37 Military Hospital (37MH) Institutional Review Board (IRB) at a full Board meeting reviewed and approved your protocol.

**TITLE OF PROTOCOL:** An exploration of Perceptions on Family Centred Care Concept for Trauma Related Hospitalised Children in the Ghanaian Context.

**PRINCIPAL INVESTIGATOR:** Lilian Akorfa Obene

Please note that a final review report must be submitted to the Board at the completion of the study.

Please report all serious adverse events related to this study to 37MH-IRB within seven (7) days verbally and fourteen (14) days in writing.

This certificate is valid till 18<sup>th</sup> February 2015.

  
**DR EDWARD ASUMANU**  
(37MH-IRB, Vice Chairperson)

**37 MILITARY HOSPITAL  
INSTITUTIONAL REVIEW BOARD**

**DATE** 31/03/14

Cc: Col (Dr) Ralph Ametepi  
Commander, 37 Military Hospital

## Appendix O: Translator/transcriber's confidentiality sheet

**Title of Research Project:** Perceptions of family centred care for children in Ghana hospitalised through road traffic accident

**Researcher:** Lillian Akorfa Ohene (PhD student, DeMontfort University, Leicester UK)

I am a research student from the School of Nursing and Midwifery, DeMontfort University Leicester. I am carrying out a study on perceptions of family centred care concept for RTA related hospitalised children and I would like to work you to translate/transcribe my individual interviews that were conducted in Twi/English.

### Confidentiality/Anonymity

Participant's name will not be recorded on the tape or paper. Instead, a number or pseudonym will be applied. It is imperative for you to keep the information to yourself without disclosing it to other people not involved in the study.

This confidentiality requirement was explained to me by-----

I agree to keep all information confidential.

Printed Name

Printed Name

-----

-----

-----

Signature of transcriber/translator

Date

Witness

-----

-----

Signature of investigator

Date

Printed Name

## **Appendix P: Interview guide**

### **Topical areas to cover during interview with health professionals**

- Tell me about what you do here regarding children involved in RTA and their care.
- Admission type and process
- Average duration of hospital admission
- Parents/family roles
- Any policy of this hospital and unit that guide you on how to involve parents in their child's care.
- What do you know about family centred care?
- Describe the processes and procedures here, if at all that indicate family centred care
- What information do you give to parent(s)?
- When and how do you engage parent(s) in decisions making about the child's care?
- Any support parents in childcare.
- What more would you want to share on the topic of care for children involved in RTA and their parents on admission?

## **Topic areas with parents/family participants**

- Tell me about you and your child's admission to this unit.
- Apart from you, tell me who else comes to see your child on admission?
- How long are you allowed to stay with your child on admission?
- Tell me what you do for your child.
- What do the staffs say to you?
- Describe how much you feel supported in the care of your child on admission
- Which aspect of childcare have you negotiated for, or are you willing to negotiate with health professionals.
- Tell me, if at all you were involved in decision making concerning your child, and if possible share with how you feel in the decision making process.
- Tell me your views on the state of children and parents on admission and how they could be managed.
- What more would you want to share on the topic of trauma children and their parents on admission?



